UNAFFORDABLE: IMPACT OF OBAMACARE ON AMERICANS' HEALTH INSURANCE PREMIUMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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UNAFFORDABLE: IMPACT OF OBAMACARE ON AMERICANS' HEALTH INSURANCE PREMIUMS

FRIDAY, MARCH 15, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Hall, Whitfield, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Engel, Capps, Green, Butterfield, Barrow, Christensen, Sarbanes, Waxman (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Paul Edattel, Professional Staff Member, Health; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Debbee Hancock, Press Secretary; Carly McWilliams, Legislative Clerk; Katie Novaria, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Jeff Baran, Minority Senior Counsel; Alli Corr, Minority Policy Analyst; Elizabeth Letter, Minority Assistant Press Secretary; Karen Nelson, Minority Deputy Committee Staff Director for Health; Roger Sherman, Minority Chief Counsel; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

During the 2008 campaign and run-up to passage of The Affordable Care Act in March of 2010, President Obama repeatedly promised the American people that their healthcare premiums would go down by an average of $2,500 before the end of his first term in office. Unfortunately, he broke that promise. In fact, Americans' premiums have already risen by more than $3,000, and the expensive part of the ACA hasn't even been implemented yet.

It is basic common sense that if you require individuals to buy a one-size-fits-all government-mandated health plan that covers everything, rather than allowing individuals to pick the plan that best fits their needs, choice will be limited, and premiums will rise. When Obamacare adds mandatory benefits, regulations like guar-

anteed issue and community rating, and new taxes and fees on insurance plans, premiums will only grow more unaffordable for Americans, so unaffordable, in fact, that the authors of the law decided the only way to get people to buy health coverage was to force them to buy it or face a fine from the IRS.

Now, my friends on the other side of the aisle will point out that the ACA includes subsidies to help individuals buy these more expensive health plans, and they are correct. More than $1 trillion in subsidies is available for this purpose. However, households earning as little as $46,000 will be ineligible for premium assistance. Even after receiving subsidies, Americans earning as little as $25,000 will still pay more for their health insurance than they would if the ACA had not been enacted.

Making low-income and everyday Americans pay more for private health coverage is not health reform. It is making their life harder at a time when our fellow citizens face sluggish economic growth, slow job creation and little disposable income.

I recommend to all of you a report released last week by Energy and Commerce majority staff entitled "The Price of Obamacare's Broken Promises: Young Adults and Middle-Class Families Set to Endure Higher Premiums and Unaffordable Coverage." The report compiles data from over 30 studies and analyses that examine the effect of Obamacare provisions on healthcare premiums in the individual and small-group market. It also includes a State-by-State analysis of estimated increases in individual market premiums that can be directly attributed to Obamacare.

My home State of Pennsylvania can expect to see premiums in the individual market rise about 39 percent. States such as Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kentucky, Missouri, Ohio, Oklahoma, Tennessee, Wisconsin and Wyoming could see individual market premiums rise as much as 100 percent or higher due to the Affordable Care Act.

The increases for young adults in the individual market are much higher. One analysis estimates that 80 percent of young Americans earning over $16,000 will pay more for their coverage once the law is fully implemented than they pay today. And we don't have to rely merely on estimates of what is going to happen to premiums; many of the provisions of Obamacare, such as an individual mandate, guaranteed issue and community rating, have been tried before. Premiums skyrocketed, choice was limited, and these Obamacare-style reforms made it harder to find affordable coverage.

In today's economy, American families simply cannot afford to pay higher out-of-pocket health costs than they would if Obamacare had never been enacted. Our young people, many of whom cannot find jobs, cannot afford triple-digit increases in their health premiums. A central promise of the an Affordable Care Act is that health care would be more affordable under the law. For many middle-class families and young adults, that turns out to be a broken promise.

I look forward to hearing from our witnesses today. I am interested in what their research shows will happen to premiums when Obamacare is fully implemented in 2014.

Thank you.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

During 2008 and the run up to passage of the Affordable Care Act (ACA) in March 2010, President Obama repeatedly promised the American people that their health care premiums would go down by anaverage of $2,500 before the end of his first term in office.

He broke that promise.

In fact, Americans' premiums have already risen by more than $3,000, and the expensive part of the ACA hasn't even been implemented yet.

It is basic common sense that if you require individuals to buy a one-size fits all, government-mandated health plan that covers everything, rather than allowing individuals to pick the plan that best fits their needs, choice will be limited and premiums will rise.

When Obamacare adds mandatory benefits, regulations like guaranteed issue and community rating and new taxes and fees on insurance plans, premiums will only grow more unaffordable for Americans.

So unaffordable in fact that the authors of the law decided the only way to get people to buy health coverage was to force them to buy it or face a fine from the IRS.

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However, households earning as little as $46,000 will be ineligible for premium assistance. Even after receiving subsidies, Americans earning as little as $25,000 will still pay more for their health insurance than they would if the ACA had not been enacted.

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For many middle class families and young adults, that turns out to be a broken promise.

I look forward to hearing from our witnesses today. I'm interested in what their research shows will happen to premiums when Obamacare is fully implemented in 2014.

# # #

Mr. PITTS. I yield the balance of my time to—is Dr. Gingrey here?

Anyone seeking 1 minute? If not, I yield back the balance of my time, and at this point the chair recognizes the ranking member of the full committee Mr. Waxman for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman, and I thank Mrs. Capps for letting me go ahead of her and making my opening statement.

My Republican friends want to ignore the broken healthcare system we had before the Affordable Care Act. They want to ignore the tens of millions of Americans who will finally have access to affordable care coverage in 2014. And they want to ignore the fact that for the overwhelming majority of Americans, health reform will result in much more affordable coverage. I think ignoring these facts is an exercise in willful ignorance.

In the world before the Affordable Care Act, nearly 50 million Americans have been uninsured. Millions have been losing coverage every year. Millions more were excluded from coverage because of insurance company discrimination, and lacking coverage was a life-threatening condition. While tens of millions of Americans suffered in this broken market, a tiny segment of the population was able to purchase cut-rate, low-quality coverage. When insurance companies have to provide real coverage to every American, this small group of people will no longer benefit from insurance companies' rampant discrimination.

Republicans and their allies in the insurance industry have taken deeply flawed studies of this issue and tried to argue that health reform will drive up everyone's premiums. Well, that is a false claim, and I think it is irresponsible. The claims are false because they are based on studies that ignore key pieces of the health-reform legislation.

Under the Affordable Care Act, consumers will be able to purchase far more valuable and dependable coverage, and there will be limits on the overall out-of-pocket spending that insurance companies can demand. Ignoring these reforms gives a deeply misleading picture of the true cost of coverage. For young people in particular, the subsidies in the Affordable Care Act, the law's new catastrophic plan, and the ability to stay on a parent's plan until age 26 will all help keep costs low. Studies that ignore these factors do not reflect reality. The reality is that the vast majority of Americans will see their premiums stay stable or decline dramatically in 2014.

Prior to reform Americans could be locked out of coverage entirely based on a preexisting condition. They were routinely asked to pay 5 or even 10 times more than their neighbors for coverage because of their age, their gender or their health status. For these millions of people, the reforms in the Affordable Care Act will bring

costs down dramatically. That is the true story of how premiums will change under the Affordable Care Act.

We all know how important it is that every American sign up for health insurance. They will have this opportunity at the beginning of next year. It has been documented again and again that people who go uninsured are more likely to get sicker and to die younger than people with insurance. We need to be encouraging our constituents to get covered, not scaring them off with warnings about government-run health care and a radical spike in premiums.

It is past time that we in Congress work together to help smoothly implement this law. I hope that after this hearing we can move beyond political messaging to carry out the real work that the people sent us here to do. Certainly we ought to exercise our oversight, but oversight is looking at what is happening and trying to change the situation to make the laws work, not to still complain about the laws that you fought against and lost.

This law has been adopted by the Congress and signed by the President, it has been reaffirmed by the Supreme Court of the United States, and, more importantly, the people's votes in this last election reelected President Obama and Democrats to continue to support this legislation.

I don't think the majority in this House ought to see its job to continue to relitigate the legislative fight. Let us learn from realities as they will now unfold and try to make things better for everybody.

I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chairman of the subcommittee Dr. Burgess for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

Of course, listening to the ranking member does remind me of everything that has happened over the past 3 years' time, and, yes, I will admit guilty as charged to having opposed bad policy at every turn. But isn't it interesting as we sit here this morning on the eve of the third year of the signing of this bill into law that the greatest obstacle to its implementation is actually the administration itself?

Why do I say that? Well, first off, when the law was crafted, it was special interests down at the White House who actually wrote the law, the insurance companies, the pharmaceutical companies. Where were the Governors? Why weren't they involved? Governors have a big footprint in their States as far as healthcare delivery is involved. Why were they not consulted?

Of course, you had the game of hide-the-ball. Gary Cohen all but admitted it when he came to our committee a few weeks ago—a few months ago and said the administration did not want to put out the rules about the essential health benefit until after the election because they didn't want to distract people. Well, Governors needed to know that information. That is why none of them signed up for the State exchanges.

Then finally to get someone from the administration in here to our committee to do the proper oversight of the implementation, I just do not understand why it is so hard.

But to the business at hand this morning, we have all talked about how the Affordable Care Act was supposed to decrease health insurance premiums. I am going to tell you, in health care you don't get something for nothing. There is always a cost, and someone always pays it.

The Congressional Budget Office and organizations on both side of the dais have predicting drastic increases in insurance premiums for the coming years. The Congressional Budget Office predicted average premiums will rise 27 to 30 percent because of the Affordable Care Act. And we don't just have to rely on their projections. History demonstrates the negative impact of such insurance provisions. The 1990s saw huge premium increases after enacting policies that we now know as guaranteed issue and community rating.

When the Federal Government subjects health insurers to price controls, excess regulations and mandated coverage requirements, insurers must make up for the added costs, because, unlike the Federal Government, health insurers cannot run perpetual deficits, so they turn to their ratepayers to provide the additional funds. Those with the highest uninsured and unemployment rates in the Nation, individuals under the age of 40, will see their premiums increase the most, 40 to 200 percent according to some estimates.

The Congressional Budget Office and a wide range of experts have warned us from the beginning of the impending rate shock, yet Congress has failed to act. Today we will see another way the President's Affordable Care Act is anything but affordable for all Americans.

I would now like to yield the balance of the time to Dr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. I thank the gentleman for yielding, and I thank the chairman for calling this hearing today.

I commend the committee for again looking at how Obamacare will impact our country's health care. Earlier this week we heard how various provisions raised the cost to do business. Today we will now hear how it raises costs on individuals looking to purchase insurance.

The economic downturn and slow recovery has hit young Americans particularly hard. The unemployment rate for young individuals has risen higher than the national average. If a 20-something is lucky enough to have a job, he or she is likely to be underemployed with little prospect for advancement. Many are left with the inability to obtain health insurance through an employer, his or her parents or Medicaid.

The grim reality has left young people with few affordable options when it comes to healthcare coverage. In fact, more than 5 million Americans in their twenties are presently without health insurance. Five million Americans in their twenties are presently without health insurance.

The age-band compression in President Obama's health law will exacerbate this problem. And I ask you, Mr. Chairman, if our goal

was to improve the rate of individuals who have insurance in this country, why on Earth would we deliberately make it more expensive to obtain? The fact is that a 27-year-old earning as little as $33,500 a year will see her premiums jump nearly $800 next year.

We need to implement real reforms and bring healthcare costs under control. We need to lower costs for young healthy adults, not force them to subsidize costs for the older and more established Americans who can better afford.

Mr. Chairman, finding a way to lower healthcare costs for young people is not a partisan issue; it is a patient issue. We must continue to work together to ensure a healthier future for all Americans, and I look forward to working with this committee to repeal this discriminatory provision of age banding, and I will do that with the LIBERTY Act, and I ask for bipartisan support in cosponsoring my LIBERTY Act. It does just that.

Thank you, and I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California Mrs. Capps for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Mr. Chairman, and I welcome our witnesses for appearing today and look forward to your testimony.

Today we are rushing to fit in yet another hearing on Obamacare, citing fuzzy figures and speculation, and ignoring the context of the failings of our previous healthcare system and the opportunities that we now have, thanks to Obamacare. Now we have the opportunity to work together on this committee to make sure that the ACA is implemented correctly.

I am sensitive to the fact that this law changes the landscape of health care, and that is the point. Our previous system was fundamentally flawed, as this committee found in detail on numerous hearings. It was a system that allowed insurers to routinely deny coverage for even the most minor preexisting conditions like previous injuries, pregnancy, or even hay fever. It was a system that would drop coverage when families needed it most, or imposed arbitrary lifetime coverage limits, leaving families who thought they had coverage in serious medical debt worrying about how to pay the bills more than how to get better. And it was a system that allowed insurers to discriminate against the elderly and against women, charging them dramatically different rates or refusing to cover them at all, even when the vast majority of those plans offered no substantial special benefits even such as basic maternity care.

It seems like we have already forgotten just how dysfunctional our previous system was for millions of Americans who were denied any coverage, whether it was affordable or not. So I am hopeful that both sides will use this opportunity today to highlight the vast consumer protections that help affordable healthcare coverage become a reality for millions of Americans.

Now, starting in just a few months, health insurance companies cannot any longer deny coverage or refuse renewal if you happen to get sick, and, thanks to the law, they have to actually use your

premiums to provide health care or give it back. These rebates have already reached 13 million Americans. And women will no longer be legally discriminated against and charged more for their premiums just because they are a woman.

The title of today's hearing implies health insurance premiums are somehow only now a problem, conveniently ignoring the fact that premiums have been rapidly increasing for many years. Yes, in the prereform market premiums were held down artificially low for some policyholders, but that came at the expense of people having no real coverage at all when the unexpected medical bills arrived and at the expense of millions of Americans being excluded from any coverage at all. So looking only at premiums is shortsighted and misleading.

Moreover, premium costs are far from the full story. Low premiums are an illusion that routinely mask high deductibles and cost-sharing amounts that are just as significant if not more costly than the premiums themselves. New out-of-pocket maximums will limit total spending, and consumers are now guaranteed a minimum set of benefits like preventive benefits without cost sharing, which means that plans are now more valuable. These plans now value and support our health and wellness instead of just waiting for us to get sick, and premium tax credits, reducing cost sharing and provisions directed specifically for young adults will help keep insurance affordable.

On top of all these benefits, the facts are simple: The ACA has not caused widespread premium increases. The vast majority of consumers will see continued premium stability, and millions will see lower total costs right away.

So I hope today we can keep the issue in perspective and don't simply resort to the scare tactics that have become so commonplace. I believe we should continue to move forward with reform. The millions of Americans who have been waiting for health insurance cannot afford for us to go backward.

Since I have a minute remaining, I will just remind the previous speaker Dr. Gingrey that now under the coverage of the ACA, young people under 26 can stay on their parents' plan, and many thousands of them have already been taking advantage of that basic coverage within the ACA.

I yield back the balance of my time.

Mr. BURGESS [presiding]. The gentlelady yields back.

I would like now to introduce today's witnesses. We are very happy to have with us this morning a very erudite and experienced panel. Dr. Douglas Holtz-Eakin is the former Director of the Congressional Budget Office and serves as the president of the American Action Forum. Mr. Wendell Potter is a senior analyst at the Center for Public Integrity. Christopher Carlson is an actuarial principal for Oliver Wyman.

Dr. Holtz-Eakin, you are recognized for 5 minutes for the purpose of an opening statement.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, FORMER DIRECTOR, CONGRESSIONAL BUDGET OFFICE; WENDELL POTTER, SENIOR ANALYST, THE CENTER FOR PUBLIC INTEGRITY; AND CHRISTOPHER CARLSON, ACTUARIAL PRINCIPAL, OLIVER WYMAN

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. HOLTZ-EAKIN. Chairman Burgess, Congresswoman Capps and members of the committee, thank you for the chance to be here today. I do have a written testimony that I have submitted. Let me just make three points briefly, and then I look forward to your questions.

Point number one is that there are provisions of the Affordable Care Act that would lead one to believe that it would have an upward impact on premiums; and that, point number two, in order to see the magnitudes involved, we have actually undertaken some survey research and asked insurers what their actuaries are telling them about the implications for those in individual and small-employer markets; and then finally, given the evidence that there will be upward pressure on a large number of premiums, what are the implications of that more broadly for the Affordable Care Act and for the Federal budget. And I want to talk a little bit about each of those.

First, the provisions, I think, the committee is quite familiar with. There is the combination of guaranteed issue; the inability to exclude on the basis of preexisting conditions; community rating, which excludes rating on the basis of health status or gender, and limits age-rating bands to a 3-to-1 ration; the new essential health benefits, a minimum benefit package that must be adhered to; and then the overall mandate for individuals' employers to provide coverage and to carry coverage for the individuals.

Those provisions, plus some others in the Affordable Care Act, the basic coverage itself will increase demand for medical services, raise pressure on prices from providers across the Nation and thus on the underlying trend of cost care growth, and a whole series of taxes that are included in the Affordable Care Act which will be embedded into the premium structure and raise premiums as well.

If you take all of those, no individual one is particularly novel. We have seen some of this, as the chairman mentioned in his opening statement, in the States, but the experience there is not one that would lead you to think that there is going to be downward or stable premium pressures. Instead, the experience has been one of upward premium pressures where these have been tried in the past.

That is all either history or conjecture, and we have done modeling, and others have as well, but we thought the useful thing would be to go find out. So in the testimony I submitted are the results of a survey. That survey was sent to large insurers in the United States. The insurers were asked to fill out very specific questions about individuals; a young healthy individual in six particular States and markets, Chicago, Illinois; Phoenix, Arizona; Atlanta, Georgia; Austin, Texas; Milwaukee, Wisconsin; and also for older, less healthy individuals in either the individual market; and then we did the same exercise for the small-group market.

The insurers who were asked to fill this out covered the vast majority of covered lives in the United States. So while I don't represent this as some sort of representative sample of the insured population, this is a good indicator of what is going on out there.

I won't belabor every single number in the results, but in the tables we find that if you look at the younger and healthier workers across those markets, the average premium increase is going to be about 149 percent. And, as has been noted, not every premium is guaranteed to go up. Some of those provisions will, in fact, subsidize older, sicker workers, and we see modest reductions in their premiums. Our estimate is 26 percent. In the individual market you get even bigger impacts, a 189 percent increase for the young, healthy workers; less modest redistributions, small downward, 18 percent, in the premiums for the older and sicker workers.

So I think that tells us that the basic intuition about the structure of the Affordable Care Act is playing out in the market. We are going to have a combination of legislative provisions plus market pressures that will lead to higher premiums for certainly the plurality of the insured, who are the young and healthy, once the act is fully implemented in 2014.

And I guess I would say that there are a couple of implications for that. Implication number one is the question about individual take-up. The law relies heavily on a tax penalty to enforce the individual mandate to carry insurance. Given the sharp increases in premiums and the basic calculus that individuals can do, will they, in fact, take up the insurance and enter the risk pool, or will they remain outside of it and pay the tax penalty? If so, the experience will be much like the States, who had guaranteed issue, and community rating and sharp premium increases.

For employers the sharp premium increases increase a second piece of the calculus which says, you know, we are not going to provide the coverage. We will instead send our employees off to the exchanges to get insurance. And to the extent that that takes place, we will see the Congressional Budget Office estimates of the cost of the Affordable Care Act to be lower bounds. Instead, larger exchange take-up will lead to expanded budget costs, and the higher premiums will increase the subsidy per person, exacerbating the overall budgetary impact of the Affordable Care Act.

So I think this is an important issue, and I am privileged to have the chance to be here today, and look forward to answering your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

The Health Insurance Premium Impact of the Affordable Care Act: An Overview of Survey Results

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Douglas Holtz-Eakin, President*
American Action Forum

March 7, 2013

*The views expressed herein are mine alone, and not those of the American Action Forum. I thank Emily Egan, Sarah Hale, and Cameron Smith for their assistance. All errors are my own.

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee, thank you for the privilege of appearing today regarding the impact of the Affordable Care Act on health insurance premiums. The American Action Forum (AAF) keeps a close eye on the private health insurance market as well as implementation of the Patient Protection and Affordable Care Act (ACA). I am pleased to share my overview of the projected premium impacts.

I will make three primary points about the Affordable Care Act's impact on premiums:

- The requirements faced by insurers will be such that market forces push premiums higher, and health costs will be inclined to grow faster, rather than slower, as a result of the law;
- Younger Americans, who make up the plurality of the uninsured population now, will be forced to bear the largest premium increases, unless they go without insurance, which would, in turn, remove the healthiest from the insurance risk pool; and
- The structure of the law dictates that higher premiums and higher health care costs must translate into greater federal subsidies for those purchasing insurance on the exchanges. This budgetary pressure would be exacerbated by higher small group premiums, which provide incentives for small employers who currently provide coverage to drop it and expand participation in the exchanges.

The ACA and Insurance Premiums

The ACA makes a number of substantial changes to the health insurance market. While the market is currently regulated on a state-by state basis, the ACA introduces several new mandates applicable to health insurers nationwide. This testimony focuses largely on the projected impact of the law on plans operating in the small group and individual market, as gleaned from a survey of large insurers.

Premiums are the result of actuarial assessment of health care costs, benefits offered, cost-sharing requirements, and applicant data such as gender, age, tobacco use and pre-existing conditions. In 2014, plans will be mandated to expand benefits, precluded from having premiums vary based on gender or pre-existing conditions, and required to limit cost-sharing requirements overall (which includes doing away with cost-sharing for certain preventative services). While plans will be able to price premiums differently for enrollees of different ages, the range is limited to a ratio of 3 to 1. This means that costs for an older enrollee cannot exceed three times that of a younger, healthier enrollee – far below the ratios currently prevailing in markets.

Insurance plans will have to abide by the federal law in addition to relevant state regulations. It is worth noting that while the ACA allows for "grandfathered plans" – those exempt from ACA regulations – the restrictions are such that few will qualify for

grandfathered status. In practice, the major ACA reforms that come into effect in 2014 will apply to nearly all policies and significantly impact the setting premiums:

- Guaranteed issue – insurance companies will no longer be able to deny applicants;
- No exclusions for pre-existing conditions – companies will no longer be able to limit benefits for certain applicants;
- Community rating with tighter age bands – plans are unable to price plans based on the health status or gender of enrollees and are limited in their ability to price premiums based on age;
- Essential health benefits – the federal government has issued a regulation that 10 classes of benefits must be covered, with specifics to be decided by the states; and
- Mandated coverage – individuals will be mandated to purchase health insurance coverage.

Individually, these reforms are neither novel nor new. A number have been enacted at the state level. In general, when implemented without a mandate for coverage they have caused premiums to grow quickly to unaffordable levels. There is anecdotal evidence of premiums nearing $100,000 in New York, and insurers leaving the market in Kentucky altogether. Even in Massachusetts, a state that enacted a similar health reform bill that included a mandate for coverage, health care premiums are growing at an unsustainable rate.

In Massachusetts, which has a mandate and a guaranteed issue requirement in place, state health care spending on subsidized and employee coverage programs consumed 41 percent of the state budget in fiscal 2013. This is compared to 36 percent in 2010, and 29 percent in 2005. The Massachusetts health reforms went into effect in 2006. Even years after reform has been fully implemented, the state's Executive Office for Administration and Finance projects that health costs will consume 50 percent of the state budget by 2020.

The experience suggests that while supporters of the ACA argue that the individual mandate will add enough enrollees to health insurance pools to mitigate the upward pricing pressure that results from the major insurance provisions, this hypothesis has not been born out in similar state experiments.

Projected Premium Impacts of the ACA: Survey Results

In light of the analytic presumption that the ACA will place upward pressures on premiums, the overriding research question becomes: how much? To shed light on this, the American Action Forum conducted a survey of major insurance companies regarding the premium impact of the above-mentioned reforms. These results were published in February 2013.[1] Large, nationwide insurance firms, who together represent the vast majority of privately insured Americans, were surveyed regarding their projected premium changes in 6 regions

[1] http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf

(Chicago, Illinois; Phoenix, Arizona; Albany, New York; Atlanta, Georgia; Austin, Texas; and Milwaukee, Wisconsin) in the small group and individual markets. The premium impacts will differ depending on the existing, state-specific regulatory regimes that exist in the market before transitioning to the new 2014 rules. The survey goal was to pick a variety of cities including those with strict regulations on age rating and guaranteed issue (and other factors) as well as those that currently allow insurers flexibility. Using case studies also allowed one to determine premium impacts for population groups in certain markets rather than looking at an aggregate premium impact.

The survey was entirely anonymous. Survey results were submitted and aggregated by a third party, who then submitted the averages for each population and insurance market to the American Action Forum.

The major takeaway from survey results is that premium rate shock is forthcoming for the younger and healthier enrollees, whereas older, sicker, enrollees will see a reduction in premiums. On average, survey responses showed a premium increase for the younger and healthier of 149 percent in the small group market and 189 percent in the individual market. For small firms with older employees, premium reductions in the markets in question averaged 26 percent.

As shown in Tables 1 through 4, the different ACA insurance mandates have varied impacts depending on the population and insurance market. For example, the prohibition on using health status when determining premiums will raise premiums in a small group plan with younger, healthier workers by an average of 15 percent in Phoenix and 27 percent in Milwaukee. The same regulation impacts small group plans with older products by lowering premiums by an average of 29 percent in Atlanta but 39 percent in Phoenix.

Using actuarial estimates to determine premiums is not an exact science. It will be even more difficult for plans to insure a population that was uninsured prior to 2014, as their health needs and related costs may not be comparable to the previously insured population. 2014 will be a very interesting year for insurance firms navigating the new landscape for the first time.

It bears noting that in addition to the provisions in the ACA that exert upward or downward forces on premium prices, firms will also be impacted by federal rate review, which will pressure companies to keep premium costs down. It is unclear how this process will impact health plan premiums, and how it will work in concert with state insurance regulations which require plans to price premiums high enough to ensure solvency.

Table 1: Impact on Small Group Market - Younger and Healthier Workers

Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$1,865	$1,740	$2,450	$1,806	$2,374	$2,047
Elimination of group size rating factor	3%	2%	2%	1%	2%	2%
Elimination of health status rating factor	17%	15%	21%	19%	27%	20%
Elimination of gender rating factor	21%	21%	35%	21%	35%	27%
Impose 3:1 age rating constraint	40%	39%	27%	39%	33%	36%
Increase to 60% Actuary Value	10%	11%	7%	14%	11%	11%
Required new benefits (EHBs)	1%	1%	2%	1%	2%	2%
Tobacco Use Rating Factor	-3%	-3%	0%	-3%	-2%	-2%
Elimination of other allowable rating factors	6%	1%	8%	2%	2%	4%
Change in the Risk Pool	1%	5%	1%	1%	4%	3%
Miscellaneous new rules	0%	0%	0%	0%	0%	0%
New taxes & fees	3%	3%	3%	3%	3%	3%
Transitional reinsurance contributions	2%	2%	1%	2%	1%	2%
Impact of exchange on operating costs	1%	1%	1%	1%	1%	1%
Average new monthly premium	$4,551	$4,075	$6,088	$4,346	$6,562	$5,124
Average percentage increase/decrease	144%	134%	148%	141%	176%	149%

Percentage entries are impacts due to the specific factor.

Table 2: Impact on Small Group Market - Older and Less Healthy Workers

Premium Factor	Chicago, IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$13,837	$12,474	$17,742	$14,148	$14,471	$14,534
Elimination of group size rating factor	3%	2%	2%	1%	2%	2%
Elimination of health status rating factor	-30%	-39%	-29%	-30%	-35%	-33%
Elimination of gender rating factor	-1%	-1%	-1%	-2%	0%	-1%
Impose 3:1 age rating constraint	-3%	-3%	-3%	-3%	-3%	-3%
Increase to 60% Actuary Value	0%	0%	0%	0%	0%	0%
Required new benefits (EHBs)	1%	1%	2%	1%	2%	2%
Tobacco Use Rating Factor	13%	13%	5%	13%	11%	11%
Elimination of other allowable rating factors	-11%	0%	-11%	-6%	-4%	-6%
Change in the Risk Pool	1%	5%	1%	1%	4%	3%
Miscellaneous new rules	0%	0%	0%	0%	0%	0%
New taxes & fees	3%	3%	3%	3%	3%	3%
Transitional reinsurance contributions	1%	1%	1%	1%	1%	1%
Impact of exchange on operating costs	0%	0%	0%	0%	0%	0%
Average new monthly premium	$10,293	$9,247	$12,254	$10,790	$10,948	$10,706
Average percentage increase/decrease	-26%	-26%	-31%	-24%	-24%	-26%

Percentage entries are impacts due to the specific factor.

Table 3: Impact on Individual Market - Young, Healthy Male

Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$63	$43	$51	$54	$58	$54
Impact of guarantee issue with individual mandate and premium subsidies	47%	46%	44%	45%	46%	46%
Elimination of health status rating factor	19%	15%	18%	14%	21%	18%
Elimination of gender rating factor	9%	11%	24%	11%	26%	16%
Impose 3:1 age rating constraint	25%	24%	21%	26%	20%	23%
Increase to 60% Actuary Value	18%	17%	11%	17%	13%	15%
Required new benefits (EHBs)	9%	9%	8%	9%	9%	9%
Tobacco Use Rating Factor	-1%	0%	0%	0%	0%	0%
Miscellaneous new rules	2%	1%	1%	1%	1%	1%
New taxes & fees	2%	2%	2%	2%	2%	2%
Transitional reinsurance contributions	-6%	-8%	-9%	-7%	-8%	-8%
Impact of exchange on operating costs	1%	2%	1%	1%	1%	1%
Average new monthly premium	$189	$119	$143	$153	$175	$156
Average percentage increase/decrease	202%	180%	179%	183%	203%	189%

Percentage entries are impacts due to the specific factor.

Table 4: Impact on Individual Market - Older, Less Healthy Female

Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$1,167	$922	$1,021	$978	$1,363	$1,090
Impact of guarantee issue with individual mandate and premium subsidies	47%	46%	44%	45%	46%	46%
Elimination of health status rating factor	-50%	-49%	-44%	-47%	-45%	-47%
Elimination of gender rating factor	-2%	-1%	0%	-1%	-1%	-1%
Impose 3:1 age rating constraint	-10%	-10%	-12%	-12%	-8%	-10%
Increase to 60% Actuary Value	0%	0%	0%	0%	0%	0%
Required new benefits (EHBs)	7%	6%	6%	6%	7%	7%
Tobacco Use Rating Factor	26%	26%	25%	26%	25%	25%
Miscellaneous new rules	2%	1%	1%	1%	1%	1%
New taxes & fees	2%	2%	2%	2%	2%	2%
Transitional reinsurance contributions	-4%	-6%	-7%	-6%	-6%	-5%
Impact of exchange on operating costs	0%	0%	0%	0%	0%	0%
Average new monthly premium	$997	$769	$881	$815	$1,238	$940
Average percentage increase/decrease	-16%	-17%	-11%	-40%	-5%	-18%

Percentage entries are impacts due to the specific factor.

Implications

Beyond the direct impact of premium changes, these results have broader implications for the implementation of ACA. For the individual market, higher premium costs equate to a larger taxpayer burden to cover individuals with incomes 100-400 percent of Federal Poverty Level (FPL) who are purchasing subsidized coverage on the exchanges. In addition, fewer uninsured adults will be subject to the individual mandate tax if coverage would be an "unaffordable" cost to them – over 8 percent of their annual income. If the mandate tax

is not applicable, will young, healthy, uninsured individuals feel compelled to purchase insurance? Higher prices make it less and less likely.

At the other end of the age spectrum, will older Americans carry insurance year in and year out if they have unrestricted access to it when the need arises? Consider a middle-aged single adult who has had acute care in the past, but with no ongoing chronic health issues and an income of $46,000 annually (just enough to put her over 400 percent of FPL and be ineligible for insurance subsidies). If her only choices for insurance plans are over $1000 per month she is not subject to the mandate penalty/tax. When looking at table 4, the average monthly premium across the 6 markets will be *reduced* to $940. For this hypothetical adult, it may be financially beneficial to wait until insurance coverage is needed rather than purchase a plan that costs nearly a quarter of annual income.

The argument made numerous times by policymakers and stakeholders on both sides of the debate, especially during the Supreme Court's examination of the ACA's legal foundation, is that without a strong mandate, the insurance reforms such as community rating and guaranteed issue impossible. When individuals are guaranteed access to insurance products when they get sick (which is a worthwhile policy goal, of course, but more difficult in practice) they can wait until such illness occurs to purchase the insurance. Young adults acting rationally may look at a 150 percent increase in premiums and decide to opt out of the market for the time being. Older adults, such as the abovementioned hypothetical woman, may consider guaranteed issue and opt out of the market as well.

Higher premiums impact the small group employer market as well. With higher costs (or, costs that have been reduced by some percentage but stretch the budget of a small firm nonetheless) more firms may make the decision to drop coverage, especially if they have fewer than 50 employees and are not facing the penalty. There have already been many employer surveys, modeling projections and academic analyses that estimate employer drop to varying extents. Higher premiums only push the scales further toward a rational decision to drop coverage and shift employees onto exchanges where those with low or moderate incomes will have their insurance coverage subsidized by the taxpayer.

Thank you. I look forward to answering your questions.

Mr. BURGESS. The gentleman yields back his time.

Mr. Potter, you are recognized for 5 minutes for the purpose of an opening statement.

STATEMENT OF WENDELL POTTER

Mr. POTTER. Thank you, Mr. Chairman and members of the subcommittee. It is a honor to be here today.

If I may, I would like to begin with an apology to the family of Leslie Elder. Leslie died an untimely death at age 83 last summer, uninsured and facing foreclosure. I owe her family an apology because Leslie might be alive today had it not been for the work that I used to do. You see, I helped create the same kind of deceptive PR campaigns that are being waged today to weaken the consumer protections in the Affordable Care Act.

The campaigns I helped create intentionally misled the American people and their elected officials into believing that the reform of our health insurance system would do more harm than good. Among the tactics we used was hiring consulting firms and think tanks to conduct studies and surveys using questionable methodology and disclosing only the findings that could be useful talking points. These campaigns helped maintain an unacceptable status quo in which too many Americans have had to declare bankruptcy, lose their homes, and, like Leslie Elder, die much too young.

Leslie's daughter believes her mother would be alive today if she had been able to get health insurance. No company was willing to sell her an affordable policy because of her age, her gender and ultimately her serious but treatable illness.

There have been an untold number of Leslie Elders who have died prematurely because of insurance company practices that the Affordable Care Act thankfully is ending. The latest scare campaign has insurance companies professing concern about young adults, but what they really worry about is no longer being able to cherry-pick the youngest and healthiest. In most States today insurance companies are able to charge older people like Leslie 5, 6, or even 10 times more for the same coverage they gladly will sell to younger, healthier people. In some States there is no limit at all.

One of the reasons we are here today is the Affordable Care Act prohibits insurers from charging older people more than three times as much as they charge young adults. This new age-rating band foils attempts by insurance companies to deny coverage to people they want to avoid, people like Leslie Elder.

Of course, the current coordinated attack on the law fails to consider many important factors, and, as a result, the studies being cited in this campaign intentionally mislead the public. Here are some factors that the insurance industry is not talking about, but that a recent and unbiased Urban Institute analysis confirmed.

Only a small percentage of young adults will be affected, while many people at the other end of the age band will see enormous benefits that allow them to stay covered and maintain their health. There are many serious deficiencies in today's coverage, especially in the low-value, minimal-benefit coverage that is being marketed to young people. Banning junk insurance policies, those that are offered even by the biggest companies, while maintaining access to low-cost policies will mean that Americans will be able to purchase

real coverage that protects them from financial ruin if they happen to fall ill.

Discriminatory practices have for years priced many people out of the market, allowing for artificially low premiums for others. And finally, premium tax credits will soon be available that will dramatically reduce costs for many consumers.

In fact, coverage under the Affordable Care Act will be more affordable for the vast majority of young people because of the Medicaid expansion, the premium tax credits for low- to moderate-income earners, and the ability of young people to remain on their parents' policies until age 26 if they don't have jobs with health benefits. Adults under 30 will also be able to purchase catastrophic coverage with lower premiums and higher deductibles. Keep in mind that millions of young adults who have employment-based coverage will not be affected at all.

The title of today's hearing is Unaffordable: Impact of Obamacare on Americans' Health Insurance Premiums. The title implies that before the Affordable Care Act came along, premiums were stable, but now are on the verge of skyrocketing because of the reform law. Nothing could be further from the truth. But my former colleagues in the insurance industry are hoping that you will either have amnesia or turn a blind eye to the fact that premiums truly were skyrocketing before the Affordable Care Act.

The average family premium increased an astonishing 131 percent between 1999 and 2009. That is more than three times worker wages, four times general inflation, and considerably faster than overall medical inflation.

I ask Congress not to buy into the insurance industry's PR campaign. The vast majority of young adults will benefit from the law. Many for the first time will able be able to get decent, affordable coverage that will enable them to stay healthy without fear of financial ruin.

Mr. Chairman and members of the committee, many of your constituents have been counting the days until January 1, 2014, when insurance companies will no longer be able to deny them coverage or charge them far more than their family budgets can handle. Please do not dash their hopes. If you change the Affordable Care Act to enable insurance companies to meet profit goals—and that is what is really going on here, helping them to meet profit goals—then the results will be tragic, and many of your constituents will continue to be at risk of dying prematurely like Leslie Elder.

Thank you.

[The prepared statement of Mr. Potter follows:]

TESTIMONY OF WENDELL POTTER

FORMER HEALTH INSURANCE COMMUNICATIONS EXECUTIVE

BEFORE THE HOUSE ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

HEARING ON

UNAFFORDABLE: IMPACT OF OBAMACARE ON AMERICANS' HEALTH INSURANCE PREMIUMS

MARCH 15, 2013

Thank you, Mr. Chairman. It is an honor and a privilege to be here today.

If I may, I'd like to begin with an apology—an apology to the family of Leslie Elder. Leslie died an untimely death at the age of 63 last summer, uninsured and facing bankruptcy and foreclosure. I owe her family an apology because Leslie might be alive today had it not been for the work I used to do.

You see, I used to help create the same kinds of deceptive PR campaigns that are being waged today to weaken the consumer protections in the Affordable Care Act. The PR campaigns I helped create intentionally misled the American people—and their elected officials—into believing that reform of our private health insurance system would do more harm than good. These campaigns helped maintain an unacceptable status quo for far too long, a status quo that has caused bankruptcies, foreclosed homes, and many, many unnecessary deaths. Deaths like those of Leslie Elder.

Leslie's daughter believes her mother would be alive today if she had been able to get health insurance. But no company was willing to sell her an affordable policy because of her age and, ultimately, her serious, but treatable illness.

CNN ran a story on Leslie shortly after she died. It began this way:

> Leslie Elder was always a fighter. But in a message to a friend in the waning days of her life, she seemed exhausted.
>
> The note, written at a time of spiritual darkness, suggested defeat after a decades-long struggle for medical coverage.
>
> "I honestly don't know how much more I can endure," Elder wrote to a friend. I can't work. I sit in bed. I cry a lot. I am still fighting for health care and still fighting foreclosure..."
>
> As she typed the note, Elder could scarcely breathe. Her lungs had filled with fluid over several months; her respiratory system was shutting down. After visits to the

> emergency room and several free clinics, Elder was finally diagnosed with Hodgkin's lymphoma.
>
> But what makes her family bristle: Elder did not have to die.
>
> If she had had health care, "Absolutely she'd still be here," said Jacquelyn Elder, Leslie's daughter, adding that Hodgkin's lymphoma has a high survival rate. "That is something really hard to deal with." [http://www.cnn.com/2012/09/01/health/elder-insurance]

As CNN reported, the Elders had been on a nightmarish roller coaster: One minute, they had the best medical coverage; the next, they had none. And in between: skyrocketing insurance premiums, high deductibles, and stacks of unpaid medical bills.

Leslie could not get affordable health insurance, and from a strict business perspective, it's easy to see why: Insuring Leslie would not be profitable for any insurance company. This is the dilemma we face as Americans, as we try to balance the demands of a health insurance industry driven by money against the needs of friends, family, and loved ones who require insurance to survive and be productive citizens. And because I had been working in the health insurance industry, I myself helped perpetuate this grossly unfair system that rendered Leslie effectively uninsurable. For that, I sincerely apologize to Leslie's family.

During my 20-year career at two of the country's largest health insurance companies, I worked closely with CEOs, chief financial officers, and many other executives. Part of my job was providing financial communications to publications like *The Wall Street Journal*. I came to understand that investors and Wall Street financial analysts are the most important stakeholders of the big corporations that dominate the health insurance industry today. And in the course of striving to meet Wall Street's relentless profit expectations, insurers take actions that, in many cases, cause real harm to the people they're supposed to help.

Americans would be outraged if they knew a portion of the premiums they pay to insurance companies is used to create deceptive PR campaigns designed to protect profits by scaring and misleading Americans and their elected representatives. During my career, I served on numerous industry groups that carried out such campaigns to shape public opinion about health care reform. In fact, during the early 1990s, our objective was to plant seeds of doubt about the Clinton reform proposal. On that and many subsequent campaigns, we spent millions of our customers' premium dollars.

Over time, I became acutely aware of the impact these deceptive campaigns had on real families, leaving ever-increasing millions of Americans uninsured or underinsured. That awareness led to my crisis of conscience. I could no longer participate in yet another effort to derail reform, so I left my job in 2008, just as the legislative debate over the Affordable Care Act was taking shape. Since then, I've been writing and speaking out about the tactics my former colleagues and I used. Unfortunately, those tactics are being used again, this time to scare people into believing that their premiums will skyrocket if we don't perform radical surgery on the health care law.

The reality is, we are here today because of these tactics. Insurance companies and their allies have been waging a PR campaign to get Congress to change the Affordable Care Act. If we leave it up to them, we will continue price-gouging older Americans and underinsuring younger Americans, clinging to an antiquated business model that cannot solve the problems of today's America. If the insurers' campaign succeeds and stops needed reforms, Americans like Leslie Elder will remain uninsured, even after the requirement to have insurance becomes effective on January 1.

Ultimately, this is a struggle between Wall Street's well-being and the well-being of millions of middle-class and working families.

I know firsthand that insurers are eager to avoid the expense of providing coverage for people who, because of their age, might need more costly medical care. Their latest scare campaign has insurers professing concern about young adults, but what they really worry about is no longer being able to cherry-pick the youngest and healthiest.

In most states today, the industry is able to charge older people like Leslie five, six or even ten times more for the same coverage they gladly sell to younger, healthier people. That is, *if* they are willing to sell older Americans coverage at any price. In a 2009 policy paper, America's Health Insurance Plans (AHIP) acknowledged that almost one-third of people in Leslie's age group were denied coverage.

One of the reasons we are here today, of course, is that the Affordable Care Act prohibits insurers from charging older people more than ***three*** times as much as they take from young adults. By restricting the amount insurers can charge older Americans, the new age-rating band foils the industry's attempts to deny coverage to people they want to avoid—people who need medical help. People like Leslie Elder. These consumer protections, of course, worry insurance companies. But these are the very reforms needed to ensure that Americans get the insurance they need so they can remain healthy, productive citizens.

If you'll indulge me, I'd like to stop a moment and ask you to consider the hellish situation Leslie and her family were living in. Try to put yourself in Leslie's shoes: Lying in bed, scarcely able to breathe, her lungs filing with fluid, her respiratory system shutting down.

Imagine this happening to you, knowing full well that effective treatment is available, but you—someone who's played by the rules your whole life—simply can't access it. Imagine hearing the political rhetoric about how America's health care is the "best in the world," except that it's not available to you when you need it most. This, ladies and gentlemen, is **how we know our health insurance system is broken and requires reform**. And *this* is what the future will look like for many older Americans if Congress surrenders to the health insurance industry's campaign to gut the consumer protections in the Affordable Care Act.

I recount Leslie's story here today for two reasons.

First, because a lot of numbers are thrown at people on this issue. I want to make certain we don't lose sight of the fact that we're dealing with human beings here, not just entries on a spreadsheet or income statement.

Second, I want to point out the lethal consequences of the insurance market as it was before health reform. Ongoing PR campaigns run by the insurance industry, the kind I myself once helped create, are intended to sow fears and doubts about patient protections in the Affordable Care Act and turn our backs on the progress we have made.

I ask Congress not to buy into the insurance industry's PR blitz.

The 3 to 1 age band is one of many ACA protections that will correct decades-long abuses that have cost untold thousands of your constituents their homes—and even their lives.

Is it true that a small percentage of young adults will see their premiums go up next year because of the 3 to 1 age band? Yes, a few will. But most young adults will ***benefit*** from the law. Many, for the first time, will be able to get decent, affordable coverage that will enable them to

stay healthy without fear of financial ruin—not the junk insurance on the market today that provides only a fig leaf of coverage that pays little and runs out quickly.

A new report from the Urban Institute calls into question the findings of the insurer-backed studies used by the industry to support their claims about premium increases. Of course, insurers' coordinated attack on the law fails to consider many important factors, and, as a result, their use of these studies intentionally misleads the public. Among the factors that are not considered:

- The fact that only a small percentage of young adults will be affected, while many people at the other end of the age band will see enormous benefits that allow them to stay covered and maintain their health;
- The serious deficiencies in today's coverage, particularly in the low-value, minimal-benefit coverage marketed to young people. Banning junk insurance policies—while maintaining access to low-cost policies—will mean Americans will be able to purchase real coverage that protects them from financial ruin if they happen to fall ill;
- The fact that discriminatory practices priced many people out of the market, allowing for artificially-low premiums for others; and finally,
- The availability of premium tax credits, which will dramatically reduce costs for many consumers.

To make my point, an example of a young adult who will benefit from the Affordable Care Act is 29-year-old Evan Morrison of Toledo, Ohio. He has two part-time jobs, neither of which offers health benefits.

Thanks to the Affordable Care Act, Evan, who earns about $1,400 a month from his two jobs, will be eligible next year for a $2,000 subsidy to buy coverage. If he opts for a silver-level plan, his monthly premium will be about $50 a month. A bronze-level plan would cost even less. Both plans would provide comprehensive coverage and are much better options than he has now.

Evan's ability to buy affordable coverage will be the rule, not the exception. In fact, coverage under the Affordable Care Act will be more affordable for most young people because of the Medicaid expansion, the premium tax credits for low- to moderate-income earners, and the ability of young people to remain on their parents' policies until age 26 if they don't have jobs with health benefits. Adults under 30 will also have the special option to purchase catastrophic coverage with lower premiums and higher deductibles. And keep in mind that the millions of young adults fortunate enough to have employment-based coverage will not be affected at all.

The title of today's hearing is "Unaffordable: Impact of Obamacare on Americans' Health Insurance Premiums." The title implies that before the Affordable Care Act came along, premiums were stable, but now are on verge of skyrocketing because of the reform law. Nothing could be further from the truth, but my former colleagues in the insurance industry are hoping you'll either have amnesia or turn a blind eye to the fact that premiums truly ***were*** skyrocketing before the ACA slowed them down. The average family premium increased an

astonishing 131 percent between 1999 and 2009. That's more than three times worker wages, four times general inflation, and considerably faster than overall medical inflation.

Mr. Chairman and members of this committee, many of your constituents have been counting the days until January 1, 2014, when insurance companies will no longer be able to deny them health coverage or charge them far more than their family budgets can handle. Please do not dash their hopes because insurance industry lobbyists and their allies are pressuring you. If you change the Affordable Care Act to enable insurers to meet profit goals, then the word "unaffordable" in this hearing's title will, indeed, be appropriate. And the resulting tragedy would be that many of your constituents will continue to be at risk of dying like Leslie Elder.

As a final point, I ask you to recall what else was skyrocketing prior to the Affordable Care Act: both health insurance company profits ***and*** the number of uninsured Americans. Reform was long overdue and we must not turn back now. Thank you.

Mr. BURGESS. The gentleman's time has expired.

The chair recognizes Mr. Carlson for 5 minutes for purposes of an opening statement.

STATEMENT OF CHRISTOPHER CARLSON

Mr. CARLSON. Mr. Chairman and members of the subcommittee, thank you for this opportunity to testify on the impact of the Affordable Care Act on health insurance premium rates. My testimony will focus on two topics that I and the other actuaries at Oliver Wyman have studied extensively: first, the estimates we have developed on the increase in premiums that will be required to fund the health insurer taxes beginning in 2014; and, second, the analysis that we performed to measure the impact of the 3-to-1 age rating limitation of the ACA on nongroup policies.

Regarding the first topic, Oliver Wyman has researched extensively the impact of the health insurer taxes. We and others, including the CBO, believe that these fees will be passed through directly to policyholders in the form of higher premiums. Overall we anticipate that these taxes will increase premiums by between 1.9 and 2.3 percent in 2014, increasing to between 2.8 and 3.7 percent in 2018.

For the second topic, Kurt Giesa and I coauthored a article published in the American Academy of Actuaries magazine. The purpose of this article was to assess the impacts of age-rating limitations required by the ACA. Currently in most States health insurance premium rates are allowed to vary by a ratio of at least 5 to 1 based on the age of the individual. This is relative to actual costs, which may vary by as much as 6 or 7 to 1 based on age alone. Therefore, health insurers must compress the rates at the high and low ends to maintain the correct ratio of premiums based on age.

There are certain things that our report says, and there are other things that our report does not say. To be clear, our report assumes that the average overall impact of age-rating compression is a zero-sum game. Certain policyholders, those at the youngest ages, will pay more. Certain policyholders, those at the oldest ages, will pay less. But in the aggregate for all policyholders, premiums collected with and without age-rating compression will be the same.

We do not say in our report that the premiums for everyone in the individual market will increase by 40 percent, as has been quoted. In fact, we expect that most people will see a decrease in the amount of premiums they pay, primarily due to the premium subsidies offered through the ACA.

Our report is intended to measure the impact of age-rating compression; however, we also make an assumption to the impact of all other provisions of the ACA. Specifically the CBO provided an analysis of the health insurance premiums under the ACA in a letter to Senator Evan Bayh in 2009. In it the CBO estimated that nongroup premiums would increase by 10 to 13 percent relative to current law. This amount represents increases due to factors such as the actuarial value of benefits, competitive factors and the enrollment of uninsureds. For our analysis we assumed that the impact of these other factors would be at the low end of this range or 10 percent.

Our report illustrates the impact on premiums for those individuals that are not eligible for the subsidies. What our report shows is that for individuals in the lowest age bracket, ages 21 to 29, premiums would increase by 42 percent due to age rating and other factors, or 29 percent due to age-rating compression alone. Further, individuals at ages 30 to 39 would see an increase of 31 percent, or 19 percent due to age-rating compression only. At the other end, individuals at ages 60 to 64 would see their premiums increase by 1 percent for all factors, or decrease by 8 percent due to the age-rating compression.

There are several factors that should be considered when understanding the results in our report. First, our purpose was to illustrate one of the unintended consequences of the ACA. While most individuals will see their premiums decrease as a result of the premium subsidies available on the exchanges, there are certain individuals, primarily those under the age of 40 and that are not eligible for any premium subsidies, whose premiums may increase substantially due to the limitations on the age rating.

Second, individuals under the age of 30 have an alternative to purchasing at premium rates that are affected by the age-rating compression. They may purchase a catastrophic policy, which, under the rules set by the Department of Health and Human Services, may have a rating factor that adjusts the premium to reflect the expected demographics of the enrollees. However, this severely limits the options available to younger individuals in selecting a policy.

Mr. Chairman, again I thank you for the opportunity to speak, and I look forward to answering any questions.

[The prepared statement of Mr. Carlson follows:]

Unaffordable: Impact of Obamacare on Americans' Health Insurance Premiums

by

Christopher Carlson
Principal and Consulting Actuary
Oliver Wyman

for the
House Energy and Commerce Committee
Subcommittee on Health

March 15, 2013

I – Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Chris Carlson, Principal and Consulting Actuary at Oliver Wyman. I have nearly twenty years of experience as a health care actuary and have been actively involved the last few years in helping stakeholders, including clients, regulators and actuarial colleagues understand and implement the changes required by the Affordable Care Act (ACA). I am delighted to have this opportunity to testify on the impact of the ACA on health insurance premium rates.

As an actuary, I represent a profession that maintains high standards of professionalism and provides critical independent thought and analysis to educate the policy decision makers on issues of great importance. Our work that is detailed in this testimony has been performed under the guidance of the Actuarial Standards of Practice.

My testimony will focus on two topics that I and the other actuaries at Oliver Wyman have studied extensively. These topics are:

- The analysis that we performed to measure the impact of the three to one age-rating limitation of the ACA on individual policyholders.
- The estimates we have developed on the increase in premiums that will be required to fund the health insurer taxes beginning in 2014.

Overall, we note that the age-rating limitations result in no change in the average premium. However, since current age-rating laws in most states allow for a five to one ratio in the highest to lowest rate, the change in the premium required for certain policyholders to compress to a three to one ratio is significant. Our study indicates that the impact of the age rating compression

will increase the average premium for policyholders between ages 21 and 29 by 29%. When combined with other changes in the market, such as increased actuarial value of benefits and essential health benefits, the overall increase in premiums for the policyholders ages 21 to 29 may be 42%. We note that this increase would only apply to individuals that are not eligible for any premium subsidies and have incomes above 400% of the Federal Poverty Level.

Beginning in 2014, health insurers will be assessed additional premium taxes required by the ACA. The amount to be collected in 2014 is $8 billion, increasing to $14.3 billion in 2018 and with trend thereafter. We estimate that the impact of these taxes will be to increase premium rates by 1.9% to 2.3% in 2014, and by 2.8% and 3.7% in years 2018 and later.

II – Age-Rating Under the ACA

The ACA reforms the market rules that all health insurance providers must follow in the pricing of health premiums beginning on January 1, 2014. In general, premium rates are only allowed to vary by four criteria: geography, age, tobacco usage and actuarial value. Of these, there is a further restriction that the premiums may not vary by age by more than three to one from the highest age tier to the lowest age tier. In fact, the regulations that were promulgated by the Department of Health and Human Services mandated specific factors by age to be used, unless otherwise developed by an individual state.

Kurt Giesa and I, actuaries at Oliver Wyman, co-wrote an article for *Contingencies* magazine, which is published by the American Academy of Actuaries, which estimated the impact of the age rating compression on different age cohorts in states that currently allow age rating beyond three to one. The importance of this work is to help move beyond looking at premium changes based on broad averages, especially in a case where an average would mask substantial

differences. We believe it is especially important to look at the age cohort from 21 to 29, since even after accounting for ACA's provision requiring that adult children be allowed to remain on their parents' coverage until age 26 this age group has an uninsured rate that is roughly twice the uninsured rate for the nonelderly population.

To create our study, we used three primary data sources. The first was the 2011 Current Population Survey (CPS) conducted by the U.S. Census Bureau (use of the 2011 CPS data takes into account the impact of the ACA's adult child coverage provision, which became effective for plan years beginning on or after Sept. 23, 2010). For premium-level assumptions, we relied on Congressional Budget Office (CBO) estimates regarding selection and impact of increased benefit levels tied to actuarial values. We excluded the effects of medical cost trend because it's assumed to occur regardless of the ACA. (CBO estimates of premium increases include growth in the underlying cost of coverage related to an increase in benefits over what is purchased today, positive selection due to an assumed improvement in risk pool mix, and lower prices due to greater market efficiencies.) Our estimates of the level of premium assistance are generous, as we based them on average premiums. Had we based them on estimates of premiums for the second lowest- cost silver plan (as will be the case under the ACA), the assumed levels of premium assistance would have been lower and consumer out-of-pocket costs for health insurance and the premium rate changes in 2014 would have been higher.

To construct premiums by age in 2013, we relied on a set of proprietary rating factors maintained by Oliver Wyman. These rating factors are based on costs and are consistent with factors used in the industry. For 2014, we used the standard age curve that CMS put forward in its proposed Health Insurance Market Rules. We also collected data from two large health insurance issuers to

verify our estimates derived from CPS data on demographic distributions and found similar results when looking at these carriers' actual market data.

While a range of ACA provisions will be implemented in 2014, perhaps the most important for young adult insurance premiums are the provisions for age band compression and the provisions related to advanced premium assistance tax credits and cost-sharing reduction assistance. The essence of age band compression is that younger people pay more for their coverage so that older people can pay less. As with many other issues that affect pricing, this is effectively a matter of the amount of cross-subsidization that will flow among different enrollees with respect to their health insurance premiums. We need to distinguish the cross-subsidies that are the result of age band compression from the general pooling of risk that underlies all insurance. While insurance generally provides a retroactive cross-subsidy among insured individuals to protect against unknown risks, age band compression is a prospective cross-subsidy from the young to the old.

Our analysis shows that under the ACA, premiums for people aged 21 to 29 with single coverage who are not eligible for premium assistance would increase by 42 percent over premiums absent the ACA. People aged 30 to 39 with single coverage who are not eligible for premium assistance would see an average increase in premiums of 31 percent. Those with single coverage aged 60 to 64 who are not eligible for premium assistance would see about a 1 percent average increase in premiums. Our estimates of these effects are shown in Chart 1 and reflect the assumptions described above. These estimates assume a starting age band of about five-to-one, reflecting states where coverage currently is underwritten.

Our core finding is that young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the FPL, or roughly $25,000, can expect to see higher premiums than would be

the case absent the ACA, even after accounting for the presence of the premium assistance. Similarly, single adults up to age 44 with incomes beginning above approximately 300 percent o FPL can expect to see higher premiums, even after accounting for premium assistance. This is because in today's market, younger enrollees can buy coverage that more closely reflects their expected actuarial costs based on their age, and this coverage is pooled with other similar risk classes in accordance with standard actuarial principles. In addition, the ACA requires that all nongroup coverage meet essential health benefit requirements, both with respect to the type of services covered and with respect to the actuarial value of the coverage.

Consider, for example, a 25-year-old person with income at 300 percent of FPL, or $33,510. Thi person currently could purchase coverage for about $2,400 per year, or 7.2 percent of his or her income. Age band compression and the other changes to the ACA would result in premiums (before premium assistance) increasing by 42 percent to $3,408. As shown in Chart 2, this perso at 300 percent FPL will be required to pay 9.5 percent of his or her income, or $3,183, toward the cost of coverage. The cost of his or her actual premium would increase by $783, even with the $225 in premium assistance. (The impact of cost-sharing reduction assistance at these incom levels is not relevant because the assistance completely phases out at household incomes above 250 percent of FPL.)

While our analysis focused primarily on the impact of age band compression, the interaction of age band compression and the elimination of premium variation related to health status also deserves attention. Analysis of representative carrier data suggests that eliminating health status as a rating factor itself may increase premiums by roughly 17 percent to 20 percent for those wh have preferred rates because of lower-than-average health risks. Young adults often qualify for these preferred rates. These increases would be in addition to any premium rate change due to

age compression, required increases to benefits, or other factors discussed above. On the flip side, older individuals often cannot get coverage in the nongroup market or afford coverage if it is offered. The ACA addresses many of these concerns for older persons separate from the issue of age band compression. It mandates that nongroup coverage be offered on a guaranteed-issue basis. The ACA's prohibition on varying premiums based on health status will lower rates for older people. And the same arguments that apply with respect to premium assistance for younger individuals apply to those who are older—for anyone with household income up to 400 percent of FPL, the ACA makes premium assistance available that caps spending on coverage at 9.5 percent of income, or a lower amount for incomes less than 300 percent of FPL. The difference between young and old at similar income levels is that younger individuals at a given income level are much less likely to find it economically rational to purchase coverage if it takes up 9.5 percent of their income, while older individuals have a greater expectation of health care cost spending as a percentage of income.

In light of these trade-offs, it is important to consider ways of mitigating the effect on rates for younger people while leaving benefits of the ACA in place for older people in the pre-65 age cohort.

Breadth of Impact

Looking at the uninsured by FPL and age in 2011 shows that 11.2 million people (or almost 25 percent of the uninsured in 2011) were between the ages of 21 and 29, and roughly 1.4 million of these individuals will not be eligible for premium subsidies because their household income exceeds 400 percent of FPL. At the same time, close to another 2.6 million uninsured individuals

purchasing single coverage can expect to pay more out of pocket for coverage than they otherwise would, even after accounting for premium assistance. In total, this means that close to 4 million uninsured individuals aged 21 to 29—or roughly 36 percent of those currently uninsured within this age cohort (4 million/11.2 million)—can expect to pay more out of pocket for single coverage than they otherwise would, even given the availability of premium assistance.

Roughly 7.6 million people, or 40 percent of those covered in the nongroup market in 2011, had incomes above 400 percent of the FPL and would be ineligible for premium assistance. Taking into account both the 400 percent FPL phase-out level and the 225 percent FPL crossover point, we estimate that almost 80 percent of those ages 21 to 29 with incomes greater than 138 percent of FPL who are enrolled in nongroup single coverage can expect to pay more out of pocket for coverage than they pay today—even after accounting for premium assistance. With a crossover point of about 300 percent of FPL for those aged 30 to 44, we estimate that about one-third of those older than age 29 with incomes greater than 138 percent FPL who currently are insured with individual contracts will see higher premiums even after accounting for premium assistance.

Also of potential importance to the cost of coverage for young adults are two ACA provisions: the creation of a catastrophic plan option and coverage of adult children to age 26 through their parents' group coverage. The ACA provides that beginning in 2014 issuers can offer a catastrophic plan option to those under age 30 and to others for whom the cost of coverage is deemed unaffordable. The ACA's provisions on cost-sharing applicable to "metallic level" coverage and the actuarial value requirements do not apply to these plans. If they are substantially more affordable than other coverage, catastrophic plans may prove an important option for young adults to keep premiums affordable (though premium assistance will not be

available to those purchasing the catastrophic coverage, regardless of income). The ACA also includes provisions allowing parents to keep adult children on their employer-sponsored group coverage up to age 26. This provision is already in effect, and early indications are that it has helped to cover more young adults. Because this coverage is by definition group coverage, however, increasing dependent coverage for young adults in this way does not improve the quality of the risk pools in the nongroup market. In fact, comparing the 2011 CPS data against earlier periods suggests that one effect of the adult child coverage provision on the nongroup market has been to increase the proportion of older enrollees in relation to younger enrollees.

From a policy perspective, the issue of age band compression and whether its effect on the cost of coverage for young people is outweighed by the value of premium assistance matters for at least two reasons.

- Equity—While judging fairness and the trade-offs implicit in age band compression raises subjective questions, technical analysis can help objectively unmask distributional differences relevant to this question.

- Market Efficiency—If people aged 21 to 29 are asked to pay substantially more for their coverage than they otherwise would, will they choose to obtain or maintain coverage at all?

This question has clear implications for insurance markets, which rely on the presence of balanced risk pools in order to provide affordable coverage. Younger people tend to be healthier and have expected health care costs that are lower than those of older people. An adult near retirement age, for example, is generally expected to have health care costs that are roughly six to seven times or more than those of the average male aged 21 to 29. If healthy young people choose to leave the risk pool or join in proportionately fewer numbers relative to those with

immediate health care needs, the effect would be to create an unbalanced risk pool and higher prices for those seeking coverage.

Our analysis raises questions as to whether younger individuals will perceive coverage as cost effective. In our analysis, we blended young males with young females to look at age 21 to 29 cohorts as a whole. Had we broken the analysis out by gender, it would show a greater impact on young males (meaning premium increases would be higher and the crossover point would occur at a lower FPL level) and less of an impact on young females. The CBO's 2009 analysis of premiums under the ACA suggests that more young people would obtain coverage under the ACA than under current market conditions, leading presumably to the conclusion that risk pools for nongroup coverage in 2016 would be younger and healthier than today's markets. More recent estimates at the state level by various parties have reached different results. These analyses have focused on factors such as the impact of guaranteed issue and the elimination of underwriting. Important to all these analyses are assumptions regarding the effectiveness of the individual coverage mandate, which could encourage young people to obtain and retain coverage even if it is not otherwise in their perceived economic interest to do so. In this regard, the ACA requires that every individual maintain coverage or pay a tax penalty that is equal in 2014 to the greater of $95 or 1 percent of modified adjusted gross income, with the penalties for not maintaining coverage gradually increasing over time—phasing up to the greater of $325 or 2 percent for 2015 and ultimately the greater of $695 or 2.5 percent of income after 2016. The relatively low penalties associated with the individual mandate make the effectiveness of the mandate uncertain, particularly in the first few years of reform when stability is essential and the penalty can be expected to fall well below the annual cost of the minimum standard of coverage required under the ACA. This situation was given clarity in the June 2012 ruling from the U.S.

Supreme Court—the law does not require maintenance of coverage, only maintenance of coverage or payment of the tax penalty.

Given the significance of these issues, policymakers should assess how various ACA provisions affect the underlying affordability and cost of coverage for younger individuals, in order to better understand issues that may affect their decisions to obtain and/or maintain coverage. Understanding these issues requires analyses that go beyond consideration of broadly stated averages, which can mask the effects on important subpopulations. There are several options for mitigating the potential impact of age band compression. One approach, provided the ACA allows for this, would be to phase in the age band requirements over a period of years, thus allowing the market to stabilize with respect to other changes before full implementation of age band compression requirements. This might also bring about higher enrollment levels among young adults, which could lead to a healthier risk pool overall and help hold down premium rates for everyone— young and old.

Another complementary possibility would be to ensure that the pricing rules for catastrophic coverage provide adequate flexibility to increase the likelihood that these policies will be affordable. This appears to be the approach that CMS had taken in its recently released "Notice of Benefit and Payment Parameters for 2014." Affordability is especially important for young adults who have incomes that make them ineligible for premium assistance or are above the 225 percent FPL crossover point. For these individuals, an affordable catastrophic coverage plan could mean the difference between obtaining and going without coverage. Because these plans are not eligible for premium assistance and are limited to those age 30 and younger (and those for whom coverage is "unaffordable"), there would be a natural limiting point with respect to the number of people who would be expected to enroll. As a result, the potential impact on coverage

costs for older people because of the reduced level of cross-subsidy from those enrolled in catastrophic coverage would be limited.

III – Insurer Taxes

The ACA, establishes an annual fee on the health insurance sector – effective in 2014. The new fee applies with some exceptions to any covered entity engaged in the business of providing health insurance (including private plans that participate in public programs), but does not include self-insured employer-provided health plans. The amount of the fee will be $8 billion in 2014, increasing to $14.3 billion in 2018, and increased based on premium trend thereafter. The fees are non-deductible for federal tax purposes. As we explain later, this feature implies that for each dollar assessed and paid in fees, more than a dollar in additional premium amounts must be collected (e.g. $1.54 for every $1.00 in fees, assuming a 35% federal corporate income tax rate). In total, on a statutory basis, between 2014 when the fees are first imposed and 2019, the total amount assessed (and actually collected from health insurers) will be at least $73 billion. Net revenues to the federal government, however, will increase by a lesser amount as reflected in revenue effect estimates by the Joint Committee on Taxation ("JCT") which show federal revenues increasing by $60.1 billion over 10 years (2010-2019). As highlighted below, both the JCT and CBO conclude that the new fee on health insurance plans would increase premiums.

The CBO prepared an estimate of the impact of the market reforms required by the ACA in a letter to Senator Evan Bayh on November 30, 2009. However, in this document, the CBO made no explicit calculation of the impact of the insurer fees on average premiums in the market. Instead, they stated "these fees would largely be passed through to consumers in the form of higher premiums for private coverage."

In a June 2011 letter to Senator Jon Kyl, the JCT explained that the fee on health insurance providers is similar to an excise tax based on the sales price of health insurance contracts. They estimated that repealing the health insurance industry fee would reduce the premium prices of plans by 2.0 to 2.5 percent, and that eliminating this fee could decrease the average family premium in 2016 by $350 to $400.

Our analysis quantified the impact of the fees imposed on health insurers under the ACA on the cost of health insurance coverage in both the commercial and public sectors. Our analysis estimates that the insurer fees will increase the costs of fully insured coverage by an average of 1.9% to 2.3% in 2014, further increasing over time such that by 2023, the fees will ultimately increase costs on average by 2.8% to 3.7%. This implies a material increase the average dollar cost of fully insured coverage, raising the average cost of such coverage by several thousand dollars over a 10-year period beginning in 2014.

Mr. BURGESS. The gentleman yields back.

We will now proceed to questions. I recognize myself first for 5 minutes for the purpose of questions.

Mr. Carlson, let us stay with you. We have all seen the stories in the newspapers warning of premium increases as a result of the Affordable Care Act. The Associated Press reported that premiums could more than double in some markets and States. We are asking you here today as an actuary, and we want to know about several provisions of the law and whether you believe that they will generally increase or decrease premiums. Do they make life better or worse?

I have got limited time, so I was hoping for one-word answers here. Premiums higher or lower, life better or worse. Your choice on how you respond. But provisions such as guaranteed issue.

Mr. CARLSON. Yes, it will increase premiums. You know, it will certainly make life better for some, but from the perspective of the premiums, yes, it will increase premiums.

Mr. BURGESS. Coverage for rehabilitative services.

Mr. CARLSON. Yes, it will increase premiums.

Mr. BURGESS. Coverage for habilitative services.

Mr. CARLSON. Yes, it will increase premiums.

Mr. BURGESS. Coverage for oral and vision care.

Mr. CARLSON. Yes.

Mr. BURGESS. Limitations on cost sharing.

Mr. CARLSON. Yes, it will increase premiums.

Mr. BURGESS. Limitations on out-of-pocket maximums.

Mr. CARLSON. Yes, it will increase premiums.

Mr. BURGESS. Coverage for emergency services at in-network cost-sharing levels with limitations on things like preauthorization.

Mr. CARLSON. Yes, it will increase premiums.

Mr. BURGESS. Requirements related to annual limits.

Mr. CARLSON. Yes.

Mr. BURGESS. Requirements related to lifetime limits.

Mr. CARLSON. Yes.

Mr. BURGESS. Federal and State exchange administrative fees.

Mr. CARLSON. It may increase premiums.

Mr. BURGESS. Medical device tax.

Mr. CARLSON. Yes.

Mr. BURGESS. Health insurance tax fee.

Mr. CARLSON. Yes.

Mr. BURGESS. And, you mentioned this in your testimony. I mean, I guess the assumption of the people who were writing this was that things like the medical device tax and the health insurance fee, those dollars would be taken from the chief executives of the company. But that is not the way the world works, is it? Those monies are actually collected from the ratepayers ultimately; are they not?

Mr. CARLSON. Yes, they are. I mean, if you increase the benefits, the premiums will go up, and if you increase costs to the insurers, those will have to be funded somehow.

Mr. BURGESS. Well, let us look at, you know, proponents of the Affordable Care Act say the premiums spike as a result of these Affordable Care Act provisions will be offset by subsidies. You mention that in your testimony. Let us set aside for a moment the

question of whether it makes sense to borrow $2 trillion from foreign nations to pay for a new entitlement when current Medicare and Medicaid programs are in trouble. Let us also set aside that lowering healthcare costs, according to some on the other side of the dais, means placing expensive regulations on what Americans must buy and offsetting some of the costs for people with dollars, and all of that comes from the taxpayers. Your study addressed this claim. At what income level are some younger Americans expected to start paying more as a result of the healthcare law?

Mr. CARLSON. Well, our study looks at the age-rating compression, and individuals who are under the age of 30 who are at a Federal poverty level of 225 percent, which is roughly about $25,000, they will pay higher premiums as a result of the age-rating compression.

Mr. BURGESS. So that is sort of the break point for an individual is $25,000?

Mr. CARLSON. Yes. Yes. And anyone above that level, their premiums will be affected by the age rating.

Mr. BURGESS. Very well.

Dr. Holtz-Eakin, some supporters of the Affordable Care Act argue that the law's most expensive requirements will only fall on the individual market. I remember the discussions in this room when leading up to it, it seemed like our whole focus should be on people in the individual and small-group market, but it looks likes we made things tougher for them; does it not?

Mr. HOLTZ-EAKIN. Certainly these premium increases are going to be dramatic in the individual market for healthy individuals. Certainly.

Mr. BURGESS. We also heard from Ranking Member Waxman when he was giving his opening statement about the number of people who fall in the category of preexisting condition and can't get insurance. Now, in the large-group market, that was really much less of a problem; was it not?

Mr. HOLTZ-EAKIN. The HIPAA provisions were intended to solve that problem years ago.

Mr. BURGESS. So when he gives a figure of tens of millions of people who are unable to get insurance for a preexisting condition, that number is probably a little bit overstated; is it not?

Mr. HOLTZ-EAKIN. Some of the high-end dramatic ones simply are beyond the realm of possibility.

Mr. BURGESS. We know this, that it was a problem in the small-group and individual markets, and some States have risk pools and reinsurance to provide help there. The Federal Government set up a new program. I remember looking at these numbers right before the Supreme Court ruled, because I thought the Supreme Court was going to rule differently, as Mr. Waxman pointed out, and I thought we needed to be able to start talking about what happens to those folks who are in the Federal preexisting pool, and the number was startlingly small. It was not that they are not important people, but it was 65,000, nowhere near the tens of millions that have been talked about during the rhetoric. Is that a fair statement to make?

Mr. HOLTZ-EAKIN. Certainly that is a fair statement. I mean, as you know, I spent a lot of time looking at the high-risk pool design, and we didn't see anything like the take-up that was claimed.

Mr. BURGESS. Very well. My time is expired. I recognize the ranking member of the subcommittee, Mrs. Capps from California.

Mrs. CAPPS. Thank you, Mr. Chairman.

Mr. Carlson, the chairman asked you if the provisions in the ACA make life better or worse, and your first answer was that, yes, that guarantee issue will make life better for many people. I just want to make sure that was clear for the record.

Thank you, Mr. Potter, for your powerful story about Leslie Elder. As you know, your fellow witnesses today have produced faulty studies that ignore specific and key policies in the Affordable Care Act which actually do help lower costs for all Americans, young and old. But the key thing they ignore is that the vast majority of this Nation will benefit from an end to insurance company discrimination.

A report by the National Women's Law Center detailed the pervasive discrimination women currently face in today's insurance market. The report revealed that the same health insurance policy can cost a woman 30, 50, even 85 percent more than a man of the same age, even if maternity care is not covered, which is in itself discriminatory. These higher premiums can have a significant impact on their budget, women's budgets, costing a 40-year-old woman as much as $1,250 more each year than a man of the same age getting the exact same coverage. And let us not forget women have often been denied all coverage just because they have a previous existing condition, such as pregnancy, or having had a C-section, or being victims of domestic violence.

The Affordable Care Act ends these abuses by implementing landmark new protections for women and banning discrimination by insurance companies on the basis of gender or preexisting conditions.

Mr. Potter, can you tell us about the way insurance companies approached covering women, both young and old, prior to reform? You are knowledgeable on that topic.

Mr. POTTER. I certainly can, and the approach was to discriminate against women and people because of their age. What is important to keep in mind is that as we talk about community rating in this country, that is how health insurance began. Virtually all of the Blue Cross plans initially were—their plans were based on community rating, which meant that everyone, regardless of age or gender or health status, paid the same amount. That changed when large insurance companies began to come into the market and see that they could cherry-pick the youngest and the healthiest and make a substantial amount of money. That is what has happened, and as a consequence of that, even the Blue Cross plans had to change the way they did business.

As a result, over the years we have got a system that really discriminates, especially against people as they age and against women. You are exactly right. And they do this because when you are segmenting the population that way, and you are often charging some people so much that they don't buy insurance, and that is why we have 50 million people in this country without coverage

right now, and that helps their profits. When you have people who are discriminated against, and they simply can't afford the policies because they happen to be born with a preexisting condition called being female, then they can make a lot of money.

Mrs. CAPPS. What do you think we can expect to happen to women's premiums after the ACA really kicks in?

Mr. POTTER. They will go down. Insurance companies will no longer be able to single them out and say, just because you are a woman, you have to pay more than your brother or some other person who is of similar age, but just happens to have been born male.

Mrs. CAPPS. And do you expect this fall in premiums will be limited to women, or are there men and children, other issues will also be covered in the same way in the ACA?

Mr. POTTER. Absolutely. Virtually everyone; in fact, I do think everyone will benefit from the Affordable Care Act and get some relief from price gouging.

Keep in mind, too, it is important as we are talking about the individual market, we are talking about 14 million people. There are 315 million people in this country. That means we are talking about a population that is slightly more than 4 percent of the total population. And of that 4 percent, most of the people in that individual market will stand to benefit, become able to get coverage through the expansion of the Medicaid program, through the tax credits or subsidies for low-income earners, and for relief at the other end of the spectrum for people who have been charged up to 10 times or more for coverage in the past to the point that many of them can't buy coverage. But at least we are talking about a very small segment of the population to begin with.

Mrs. CAPPS. Thank you very much, and I yield back the balance of my time.

Mr. BURGESS. The gentlelady yields back.

The gentleman from Texas Mr. Hall is recognized for 5 minutes for questions.

Mr. HALL. Thank you, Mr. Chairman.

Mr. Holtz-Eakin, beginning in 2014, the Affordable Care Act, the Obama act, imposes a new tax on health insurance of at least $100 billion. That is an accurate figure; is it not?

Mr. HOLTZ-EAKIN. Yes, sir.

Mr. HALL. I think that our committee got that from the Joint Tax Committee, so we can live with that figure. That is good to go with. Probably none of the three here deny that figure.

Mr. HOLTZ-EAKIN. In fact, one of the unprecedented features of that tax is that it demands that a fixed amount of revenue be raised regardless of the circumstances in the industry. So $8 billion in 2014 no matter what.

Mr. HALL. And the tax begins at $8 billion in 2014 and rises to $14.3 billion in 2018, and thereafter it increases annually based on a premium growth.

I think we are all aware that the tax is going to fall on all individuals and businesses that purchase healthcare insurance. Maybe less well known or less well admitted by the writers of this act is that the tax law hits seniors enrolled in the Medicare Advantage plans, State Medicaid programs and Medicaid health plans serving low-income families. Right?

Mr. HOLTZ-EAKIN. That is correct, sir.

Mr. HALL. Can you explain for the committee what kind of impact beneficiaries enrolled in the private Medicare and Medicaid plans can expect to encounter after the tax is fully phased in?

Mr. HOLTZ-EAKIN. If you look at the structure of the tax, I think there is broad agreement that the tax itself will end up being embedded into premiums; that insurers will have to recover that cost, and the way to do so is to raise premiums.

A unique feature of the tax is that it is not deductible for purposes of paying corporation income taxes, something that I have never seen before in the tax law. So if you are not a tax-exempt insurer, if you have to pay a dollar of premium tax and you raise your premiums by a dollar to do it, you will still come up short because you have to pay tax on that dollar as well. So you have to raise premiums by more than a dollar, actually $1.54, to cover that provision. That is a lot of upward pressure on premiums. Not everyone will be subject to that, so you start to see shuffling in coverage, shuffling in lines of business. The Medicare Advantage plans, the managed Medicaids are going to be subject to the same thing. That means disruption in provider networks, higher premiums across the board.

Mr. HALL. I thank you for that.

I didn't hear you say Medicaid programs. How will the tax impact State Medicaid programs? Our Governor was in town yesterday and discussed with the Republican Members——

Mr. HOLTZ-EAKIN. It is exactly the same. All these lines of insurance are subject to this, and all will see premium pressures as a result.

Mr. HALL. Then the "yes" answers that were extracted earlier by the chairman were based on services that increase or become more expensive, and either of those situations are what you glean from reading the act itself?

Mr. HOLTZ-EAKIN. I mean, the tax is a cost that businesses have to cover for, if I understand the question right.

Mr. HALL. Thank you. I yield back my time.

Mr. BURGESS. The gentleman yields back.

The chair recognizes the gentleman from Texas Mr. Green for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. And this is not directed at you, but I guess I am frustrated, because I have been on this committee since 1977, and the Affordable Care Act was passed 3 years ago and upheld by the Supreme Court, and last session all we did was try and repeal it, and that is not going to happen. It won't pass the Senate. Yet every hearing this week we have had is to talk about how bad it is.

I would hope our committee would sometime get to the point where, OK, let us see what we can do to fix it. Instead of just making political points, we can actually pass legislation. I think that is what everybody in the country would like us to do.

But in this panel is a good example. You know, we have some great witnesses, and I have heard them before on some cases. But, you know, the Affordable Care Act is the law, and there are things in it I would like to change, and I know everybody on the com-

mittee would, but we are not going to repeal because it is not going to happen, at least for 4 years. So that is the frustration.

Let us make it work. And there are some things that are really successful, and we really won't know until next year on the success of it and when we see some of the requirements go in.

There was a report released yesterday by my colleagues, my Republican colleagues, on prediction of premium increases under the Affordable Care Act, and the Republican report ignores the fact that over 90 percent of insured Americans have employer or public coverage, which is Medicaid or Medicare. And even an unbiased observer, including the CBO, has said that 240 million people will not see their premiums increase under the ACA.

Second, the American Action Forum study totally ignores the effect of premium tax credits. These credits will go directly to the cost of coverage, immediately lowering premiums each month, and the CBO has estimated the majority of the individuals getting coverage in the exchanges would receive subsidies. And it is deeply misleading to ignore the impact of those on affected premiums.

Let me get to my questions now. Mr. Potter, is it accurate to compare a low-premium plan in today's market with the type of quality coverage that will available under the Affordable Care Act?

Mr. POTTER. No, not at all, because a lot of the policies that are sold to people, and often people enroll in these unwittingly, are plans with very, very limited benefits or very high deductibles, and people often find out when it is too late that they are woefully underinsured.

And one of the objectives of the Affordable Care Act is to make sure that people are getting value for what they buy, and that will be something that we will see as a result of full implementation of the law. We will no longer see people who are in junk policies, because they will be a thing of the past.

Mr. GREEN. Well, I have a district, and one of the highest in the country, at least the 2000 census—we haven't seen the numbers from the 2010 census—of people who work, and yet they don't have insurance through their employers. It is a very urban area in Houston, an industrialized area. And for decades, outside of their job opportunities, the next thing they ask once they get a job is, what kind of health care can I get? And some employers offer very good health care. Some offer, as you said, very limited amounts with high deductibles. Now, those are cheaper in premiums, but they also don't really establish what we hope in our healthcare world is a medical home where people feel comfortable going to instead of, even with a high deductible, are still going to show up at our emergency rooms because they don't have the coverage that will cover them.

I know you worked in the insurance industry for a long time. Just out of curiosity, did the industry ever support outside research to help generate its public relations and drive its public policy agenda?

Mr. POTTER. The insurance industry spends a considerable amount of their premium dollars on various public relations and lobbying efforts, but not so much on research that is all that reliable. The research is intended to make a point.

You know, it is not necessary for anyone's premiums to go up, we need to understand that, because we are talking about changing the way these companies will do business. There will not be quite as much need, maybe not nearly as much need, for underwriting.

McKenzie & Company did a study of health care costs around the world in 2008, and it showed in the U.S., of the administrative expenses of insurance companies, by far the largest component of that are marketing and underwriting expenses. And that is just not going to be all that necessary, because you are not going to be needing to use all of those resources.

Mr. GREEN. I am almost out of time. Again, having served in the Texas Legislature and trying to deal with the uninsured, it was almost impossible. We created high-risk plans, but the only people that went to them were high risk. And the State wouldn't put any money in, so nobody could afford the coverage. So one of the best reforms in the Affordable Care Act is the 80 percent requirement that they have to pay out in medical benefits. I know physicians like that, hospitals like that, because they actually know that they are going to receive the payments.

Mr. Chairman, I know I am out of time, and I appreciate your patience.

Mr. BURGESS. The gentleman yields back.

The chair recognizes the gentleman from Illinois Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman, and I know my friend from Texas is still in the room. I would just like to remind him that we had not one hearing on this healthcare law before it was passed on the floor. There was not one.

Then number two I will say, as ranking member of the Health Subcommittee, the remaining part of that year, every week I asked for the chairman of the Health Subcommittee to have hearings on how this law would be implemented, and we were never offered one.

So what we are trying to do now is at least—is the whole "we got to pass the bill before we know what is in it." Now we are trying to figure out what is in it, and that is what these hearings are part of.

Everybody is going to get a chance to ask our witnesses, and we are going to be able to make our points about the benefits and the disadvantages. But don't trash the system that legislators need to do, which is our oversight role in this body.

So I wouldn't respond forcefully except for I was the ranking member of the Health Subcommittee when this law got passed. Nathan Deal was—when the law was passed, Nathan left to run for Governor. I assumed that role, and for the final part of that Congress, every week I asked for a hearing on this piece of legislation, and every week it was denied.

Mr. GREEN. Would the gentleman yield?

Mr. SHIMKUS. I would be happy to yield.

Mr. GREEN. Well, you understand how it feels to be in the minority.

Mr. SHIMKUS. I definitely do.

Mr. GREEN. My quote was—and you remember we had literally hours and hours, including very late markups on the bill. Now,

having said that, we should have had follow-up hearings on the implementation.

Mr. SHIMKUS. Just reclaiming my time, the bill that was passed was the Senate bill, without hearings, without movement through the committee. It was picked up from the Senate and passed on the floor.

Mr. GREEN. Would the gentleman yield?

Mr. SHIMKUS. I am just telling you the facts.

Mr. GREEN. And again, I agree that that happened. The problem is that we didn't have an alternative. Believe me, the majority, no matter who is in the majority, does that same thing.

Mr. SHIMKUS. Reclaiming my time, it was the Speaker at that time who said the American people, we have to pass the bill before we know what is in it.

Mr. GREEN. That wasn't my——

Mr. SHIMKUS. All we are trying to do now is to find out what is in this piece of legislation, so I applaud this series because it is not even rolled out. It is not in full implementation yet. So that is—I mean, again, that is what we are trying to do. And I wanted to ask just Mr. Potter, and it is kind of key to this last comment about 80 percent, you know, has to go to services in the plan and part of that debate was an analysis about how much administration planned that our Medicare system funds during the debate. Do you know what that percentage is of the overhead cost is the bureaucracy of Medicare?

Mr. POTTER. Well, the medical loss ratio, the equivalent of that in the Medicare program is considerably lower.

Mr. SHIMKUS. Do you know what that percentage is?

Mr. POTTER. I have heard that the administrative expense is about 3 percent in the Medicare program.

Mr. SHIMKUS. And that is the numbers that I used. That is the numbers my friends on the other side used.

Now, can you tell me which health insurance plan the private sector of the market or the government run market is actually unsound and going broke?

Mr. POTTER. I think the current commercial system is absolutely unsustainable.

Mr. SHIMKUS. OK. The question is, Medicare or the private health insurance market, which one is going broke?

Mr. POTTER. I don't know, sir.

Mr. SHIMKUS. OK. Let me ask Mr. Carlson. Do you have an idea?

Mr. CARLSON. Well, I certainly think that the commercial market is not going broke, and that is why they have actuaries to make——

Mr. SHIMKUS. Right. And we haven't asked you that is why they have actuaries to make sure they don't go broke.

Dr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. The government has actuaries but it is still going broke, sir.

Mr. SHIMKUS. And that is really this part of this fight we are having in Washington and how we can actually reform the entitlement programs so that we are not in a $16 trillion debt. Obamacare makes the program even worse because it creates a new entitlement that is not funded that makes actuarially, sir, Mr.

Potter, our Nation less sound today, next year and in the foreseeable future.

I yield back my time.

Mr. BURGESS. The gentleman yields back. The chair recognizes Mr. Sarbanes of Maryland 5 minutes for purposes of questions, sir.

Mr. SARBANES. Thank you, Mr. Chairman.

Dr. Holtz-Eakin, do you think the Affordable Care Act can work?

Mr. HOLTZ-EAKIN. I am sorry, sir?

Mr. SARBANES. Do you think the Affordable Care Act can work?

Mr. HOLTZ-EAKIN. I am skeptical, to be honest, sir.

Mr. SARBANES. OK. Mr. Carlson, do you think it can work?

Mr. CARLSON. I think there are things within the law that could be changed, but you know, I can't comment overall whether it is going to work and——

Mr. SARBANES. It could work.

Mr. CARLSON. It certainly could work but it may not work.

Mr. SARBANES. Americans could make it work.

Mr. CARLSON. Potentially, right.

Mr. SARBANES. How would you define work?

Mr. Potter, do you think it can work?

Mr. POTTER. I do. I think it can work. I think that we will—as you bring more people into coverage, you make a big difference and you begin to end some of the cost shifting that is so problematic in this country, and that contributes to all of us paying more in insurance premiums as a consequence.

Mr. SARBANES. Do you think the system we had before was workable over time?

Mr. POTTER. Not at all, not at all workable, nor was it sustainable either. You cannot keep raising premiums, as I said. They increased 131 percent between 1999 and 2009. You can't keep doing that and you can't—and at the same time insurance companies were shifting more of the cost of care from them and from employers to employees and dependents. You can't keep doing that and expect that that system is sustainable. It is simply not.

Mr. SARBANES. What I am concerned about is there are—we can all agree that there is going to be some increases for some portion of the population as a result of implementation of this, but we are talking about increases within that individual market for younger healthier people who are more in a position to afford those increases than their peers might be because if their peers can't afford it, they are going to be able to take advantage of these Affordable Care credits, these tax credits when they go into the exchanges, so you are talking about a relatively small number of people who may experience, and I think arguably in an affordable way, an increase in their premiums, but based on that, we keep getting this phrase of a rate shock and so forth being bandied about, and I am trying to figure out why that is happening. Like, what is afoot with it?

So if the industry is the one that is putting out this rate shock narrative when in fact there is going to be good stability for the great majority of consumers out there and actually reduce premiums for many, if the industry is doing it, subscribing to this narrative, I can only surmise that they are doing it because they are getting ready or setting the table for some potential rate gouging.

Now, if the industry is not intending to do that, and I will give them the benefit of the doubt for the moment that they don't want to rate gouge, that they do just want to present the straight story on it, then what is really happening is that long time critics of the Affordable Care Act are putting that narrative out as a way of just fear mongering about the Act generally.

Do you, Mr. Potter, you have been there, you have been inside that, that mindset. What is going on here? Why are we getting this sort of rate shock narrative being pushed out to Americans right now? What do you think that is all about?

Mr. POTTER. Well, insurance companies spend a lot of money trying to influence public opinion to influence public policy, and that is what is going on is to create an impression of something that is not reality and is not likely to be reality.

Keep in mind, too, that these may be, the increases we are talking about may be what they would like to get and they would be able to get in the absence of the Affordable Care Act, but we have—there are provisions in the law that will require reviews of excessive rate increases, and——

Mr. SARBANES. Thank goodness for that.

Mr. POTTER. Yes. So, just because they say they want to do this or plan to do this doesn't mean they are going to be able to do this.

Mr. SARBANES. So, at the end of the day, it is a completely nonconstructive exercise.

Mr. POTTER. It is.

Mr. SARBANES. The key is nothing to do this, to put that narrative out. It just puts people on edge and it is going to make it harder for us to make this thing work, and it can work if we put our heads behind it.

Mr. POTTER. You are right. And keep in mind again, we are talking, as you noted, about a very small segment of the population. But the intent here when you talk about rate shock, which is a crock, if you ask me, is nothing more than to try to get the impression that we are talking about the whole population, and it is not that at all. It is a small percentage of the population.

Mr. SARBANES. Rate shock is a crock. Thank you. I appreciate that.

Mr. BURGESS. Gentleman's time has expired.

Chair recognizes the gentleman from Louisiana, Dr. Cassidy.

Mr. CASSIDY. OK, Mr. Potter, if rate shock is a crock, why does Massachusetts, which has the beta version of Obamacare, which has exchanges, nonprofit insurance companies; i.e., no marketing apparently and no need to do actuarial testing and has MLR requirements, they have the highest small business premiums in the Nation? Now, it doesn't make sense to me that if the beta version is giving us this, that there won't be a rate shock.

Mr. POTTER. Massachusetts is a great State. It is a prosperous State. It also has some of the best medical facilities in the country. Health care in Massachusetts is expensive. It is much more expensive in Massachusetts than in many other States.

Mr. CASSIDY. So you don't draw a connection between the fact that they have Mass Health and the fact that they have higher premiums is just a function of the providers charging more.

Mr. POTTER. Providers have always charged more in Massachusetts, so that is——

Mr. CASSIDY. They have had a rate of growth that exceeds the rest of the Nation since putting in Mass Health, I think that is what it is called, so again, it is your position, though, that there is nothing inherent. They have got nonprofit insurance companies, et cetera, that there is nothing inherent in the plan that contributes to the upward pressure.

Mr. POTTER. I think that in the plan, the things that are in the Affordable Care Act to mitigate the cost increases, you are not going to see necessarily, as I said, a lot of cost increases in this country.

Mr. CASSIDY. Well, I guess we have to agree to disagree because Mass Health seems to belie what you are saying.

Secondly, you spoke negatively of the plans that people would afford, suggesting that they are basically catastrophic, and let me just hold up the Kaiser Family Foundation, and Kaiser is kind of all in for Obamacare, but it points out that the average small business or the average business has an 80 percent actuarial value. We know from McKenzie that about a 30 percent of businesses will dump their employees into the individual market. I mean, that is according to the McKenzie survey, and so then they will probably choose the bronze plan. And the Kaiser Family Foundation study shows that these people will go from something of higher actuarial value to something of lower actuarial value and that deductibles in the employer plans are about $1,900, but their deductibles, their out-of-pocket will be as much as 6,000 and higher for a family in the exchange.

And they compare the bronze level plan, Kaiser Family Foundation does, with that of a catastrophic policy. So I guess if your position is the catastrophic policy is no good and yet people will most likely be on a bronze level plan with the catastrophic-type coverage, are you indicting the bronze level plan?

Mr. POTTER. Not at all. The catastrophic plan, while not as generous and will have higher deductibles, you are right, than the other plans. It still will be far better than a lot of the policies that are being marketed in this country. I have met people——

Mr. CASSIDY. But again——

Mr. POTTER. Congressman, I have met people who are $50,000 a year families, policies with $50,000 annual deductibles. They pray every night they don't get sick.

Mr. CASSIDY. So the nice thing about an HHA plan currently is that you can actually prefund on a tax preferred basis, and you actually have that to meet your front-end cost. Under the bronze plan, there are actually deductibles and copays that will have to be hit up to $4,000 before you get complete coverage. There is no first dollar coverage. I suppose the employer could elect to go to an HHA. The current rules are prejudiced against that. I think that we are hearing a mixed message from what you are saying and what the facts are.

Dr. Holtz-Eakin, at a later time you can tell me why your name is hyphenated, but that is OK.

Mr. HOLTZ-EAKIN. It is a long story. Maybe another time.

Mr. CASSIDY. Listen, let's assume that what our colleagues say on the other side of the aisle, which I actually agree with, as long as President Obama is President we are not going to repeal Obamacare. I mean, he has got too much invested. What could we do—if it is the law of the land, what could we do to bring premiums down.

Mr. HOLTZ-EAKIN. Certainly the pressures and premiums come from the underlying growth in health care costs, and I think there is now a bipartisan consensus that nothing has really been done to break that trend. There is the layer that comes from taxes and mandates to raise those premiums, and one could modify those as well, and then the rest of the plan is just large amount of puts and takes because, you know, some people will do better and worse because they are going to redistribute from one group to another.

Mr. CASSIDY. Let me ask you——

Mr. HOLTZ-EAKIN. And that is that——

Mr. CASSIDY. I think empirical data shows that consumer-driven health care have lowered cost.

Mr. HOLTZ-EAKIN. Sure.

Mr. CASSIDY. Would you agree that if we could more encourage consumer driven health care that we would have the same trend we have been having that that this is lowering cost if that could continue under the ACA?

Mr. HOLTZ-EAKIN. Allowing people greater choice for plans that match their needs and provides some competitive pressure has always worked.

Mr. CASSIDY. OK.

Mr. Chairman, I yield back.

Mr. BURGESS. Gentleman yields back his time.

The chair recognizes Dr. Christensen 5 minutes for purposes of questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And while we all agree that we could work to build on what the Affordable Care Act needs to strengthen Medicare, I just want to make it clear for the record that Medicare is not going broke. Costs have grown by less than 2 percent over the past 3 years and private insurance costs have really always grown much faster than that.

Let me see if I can get two questions in. The Affordable Care Act takes a number of steps to ensure that Americans have access to quality affordable coverage, that it is there when they need it, and these new protections has been discussed with me and you, Mr. Potter and Mr. Green, offers stark contrast to some of the junk insurance that is on the market today, some of which is in my district, unfortunately.

All the plans sold in the exchange will have an actuarial value of 60, 70, 80, or 90 percent, and plans will have to cost essential—cover essential health benefits and also offer preventive care with no cost sharing. So these requirements will significantly increase the value of insurance coverage for millions of Americans. The cap on out-of-pocket spending guarantees that individuals with serious health needs will never again face endlessly increasing cost sharing. In order to receive needed care, the end of lifetime limits on coverage and the phase out of annual limits ensure that coverage

remains intact even if an individual's health care needs increase dramatically in a given year or as the individual grows older.

So, Mr. Potter, all of these seem to me like common sense elements of quality insurance. So can you tell us why, in your experience, the insurance companies you used to work for are opposed to these reforms?

Mr. POTTER. They make a great deal of money selling policies that are inadequate, and if you are selling policies you don't have to pay very much out in claims, that goes right to the bottom line, and you are able to increase your profit margins, and why——

Mrs. CHRISTENSEN. And I guess that is why they are not going broke either.

Mr. POTTER. That is why they are not going broke and they are able to maintain their profit margins because of pressure from Wall Street they do these things, but they—and they have invested quite a lot of money, some of the biggest companies buying smaller companies that specialize in limited benefit plans that can almost guarantee that someone is going to be underinsured if they get sick.

Leslie Elder didn't plan to get breast cancer. My son didn't plan to break his hand last year and find, because he is in a high deductible plan, that he is paying a lot of money out of pocket. He, by the way, before the Affordable Care Act was passed, was told—he was in the individual market—that his policy was going to be increasing 66 percent unless he switched policies and go into a policy that had a deductible that is 10 times what he had been paying.

So, again, we—hindsight is a lot clearer than looking ahead. We know what has been happening and the price gouging that has been going on, and really we are talking about profits here.

Mrs. CHRISTENSEN. So when the insurance companies say they want to offer choice and provide new low cost options, you are talking about these junk things——

Mr. POTTER. That is exactly right.

Mrs. CHRISTENSEN [continuing]. That are being sold on the market for big profits.

For consumers young and healthy enough to be able to afford coverage in the individual market prior to reform, the coverage they had was really only an illusion. Insurance raised rates, high cost sharing disappeared when the consumers really needed them, and we saw this in many of the hearings that we had leading up to health care reform, of which there were many.

A recent analysis found that the premiums in the individual market are so unstable that 80 percent of plans raise premiums above the price consumers were quoted when they applied for the coverage. This so-called affordable option that my Republican friends think existed before health reform are really unstable and unreliable. It is also wrong to call today's low premium plans affordable because of all of the other charges that hit consumers as soon as they actually need the insurance.

And these plans set hard annual and lifetime limits on the amount of care coverage which leaves consumers completely in the lurch if they ever have a serious medical need as the person you spoke about.

So, Mr. Potter, the studies my Republican friends are relying on today are focusing on comparing low premium plans available to day to premiums and plans that will be available under the Affordable Care Act. Would these premiums likely have stayed stable and provided real coverage if a person got sick?

Mr. POTTER. Not in the old world. Not in today's world. They would not have remained stable. We have seen premium increases over the years, and they would continue.

Mrs. CHRISTENSEN. So, this is just another reason that comparing past premiums in the individual market to future premiums makes no sense. My Republican friends ignore the subsidies available to consumers, they ignore the key limits on cost sharing when they compare real quality coverage to the bait-and-switch insurance available today.

So, thank you for your answers, and thank you, Mr. Chairman. I yield back.

Mr. BURGESS. Gentlelady yields back.

The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for the purposes of questions.

Mr. LANCE. Thank you, Mr. Chairman, and good morning to the panel.

To you, Mr. Potter, I am concerned about pre-existing conditions, as I know you are from your testimony, and I think we should work together regarding that issue.

The Centers for Medicare and Medicaid Services recently announced that they were no longer accepting applications for the pre-existing condition program created by the health care law and I think that this is a challenge that we have to work together to solve. I think this could lead to countless chronically ill Americans, including the vast majority of the rare disease community from not receiving treatments, and I have the honor of chairing with Congressman Crowley of Queens in New York City the Rare Disease Caucus, and recently our leadership here in the House on the Republican side, Speaker Boehner, Majority Leader Cantor, Whip McCarthy, Conference Chair McMorris Rodgers, who serves on this committee, Chairman Upton, Chairman Pitts, and Dr. Burgess sent a letter to the President regarding the fact that the Centers for Medicare and Medicaid Services announced that they were no longer accepting applications for the pre-existing conditions program.

I am wondering what your thoughts might be as we move forward to try to address this issue together since one of the promises of the Health Care Act was that this program would be put in place and that we would have solved this problem but clearly we need to do more work on the area.

Mr. POTTER. When you are segmenting—pardon me. When you are segmenting people with pre-existing conditions into high risk pools, by their very nature they are going to have people who are sicker and who will have higher medical cost, and one of the reasons why it is important to move to at least a modified community rating approach to providing health coverage is that you can broaden the risk for everyone.

Keep in mind that people who are sick, who have pre-existing conditions and might look to get coverage through a high risk pool

often may not be able to work. They may not have the ability to buy into a high risk pool. One of the reasons why maybe we haven't seen as much uptake in the high risk pools in the States is because the premiums are expensive and the people who are sick and who need them just often simply can't afford to buy them. So we do need to make sure that people who have pre-existing conditions are taken care of.

We are all in this together. I think that if we can look beyond our own current circumstances, we might realize that a friend of ours or a brother or a daughter or a son might have a pre-existing condition and have need for medical care, so we have got to look beyond our own current situation sometimes.

Mr. LANCE. The $5 billion program created by PPACA was intended to help individuals with pre-existing conditions through January 1st of next year, and as I understand it, despite lower than expected enrollment, CMS announced it would no longer enroll individuals, and it seems to me this is a reminder, and there have been several, that the cost of PPACA are significantly understated, and those who may need help are no longer going to be able to enroll in the program.

Mr. POTTER. It is possible, but also there is not a great deal of awareness, I don't think, of coverage that is available or the high risk pools. Leslie Elder, as CNN reported, conceivably could have been enrolled in a high risk pool in Florida, but she and her husband just simply were not aware of the existence of it, so at the end of her life, conceivably she died after the Affordable Care Act was passed and she might have been able to have enrolled in a plan that they could have afforded but it just wasn't something that was available or they were aware of its existence.

Mr. LANCE. It might have been available, but from your perspective, she was not aware that it was available.

Mr. POTTER. That is what was reported and her husband said he was not aware of it as well. I talked to him just recently and he wasn't aware that it could have been available to them. So these are not—you know, States don't necessarily have large marketing budgets like insurance companies do.

Mr. LANCE. I think we have to work on this issue together, and I am sorry that PPACA has not reached its promise in this regard, particularly regarding the rare disease community of great interest to me since I chair that caucus with Congressman Crowley of the neighboring State of New York, and I think we have to work together and do a better job, and I think that was the intent of the leadership position in the letter written by Speaker Boehner and our other leadership to the President as we try to solve this issue together.

Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman yields back.

The chair recognizes the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions, sir.

Mr. GINGREY. Mr. Chairman, think you. I want to reflect back just for a minute on the line of questioning between Mr. Sarbanes from Maryland and also Mr. Cassidy from Louisiana with Mr. Potter, and I think, Mr. Potter, I am going to paraphrase this a little bit but the quote being rate shock claims are a crock. I wonder how

he feels about the President's claims about the effects of sequester as he went around the country several weeks before sequester went into effect and indeed closing the White House tours for our families and young people who are coming to the Nation's capital to see the people's House and have an opportunity during upcoming spring break.

That being said, I am going to direct my first remarks to Dr. Holtz-Eakin. Dr. Holtz-Eakin, as a former Director of the Congressional Budget Office, you are well aware of how legislative decisions are scored and how they affect our economy. Your current organization, American Action Forum, released a survey which found that for a 27-year-old in Atlanta, where I hang out, the age band compression to a 3-to-1 rating would result in a 27 percent increase in premiums. Now, these are young people above the age of 27, by the way. Ms. Capps earlier stated that I was ignoring the fact that young people up to the age of 26, many of them are on their parents health insurance policy, but we are talking about people that are beyond that. 27 percent increase in premiums.

These individuals, as you are aware, Dr. Holtz-Eakin, face uncertain job prospects and record education debt. Many of them, of course, stayed in school because they couldn't find a job and they continued on Stafford loan program and, you know, building up more and more education debt, hoping at the end of that time to be able to find a job.

Well, the penalty for not purchasing insurance next year will be $95, and many of these 27-year-olds, 28-year-olds haven't found a job yet. In some cases, a 27-year-old making only $33,500 a year will see premiums increase roughly $800. So, Dr. Holtz-Eakin, in your opinion, will young people be more likely to purchase expensive health insurance or pay the relatively low fine next year?

Mr. HOLTZ-EAKIN. Well, thanks for your question. If I could at the outset, can I just for the record make it clear that this survey was entirely my idea. Mr. Potter insinuated that all such studies are bought by insurance companies. We thought it up, we designed it, we requested the information because of our longstanding interest in this legislation, and the results were delivered in a blind fashion. I have no idea who responded, and the aggregate data were released by us as a matter of public information.

What the data say are pretty clear that if these rate increases take place in markets, it will be cheaper to pay the penalties than to purchase the insurance.

Mr. GINGREY. Thank you, Dr. Holtz-Eakin.

Mr. Carlson, I am aware that you have decades of experience as a health care actuary. In fact, without you, insurance companies would go broke. In your opinion, if these young people that Dr. Holtz-Eakin referenced failed to purchase health insurance, how would premiums react for the rest of the population if fewer and fewer of these young people, beyond the age of 26, particularly, stay out of the market?

Mr. CARLSON. Well, even with the current age rate and limitations in most States, which is 5-to-1, there is a bit of a subsidy going from the younger generation to the older generation, so we would expect that their—if those younger individuals do not enroll, if their premium rates are higher than what they are willing to

pay, there would be an impact of increase in the rates for the rest of the industry.

Mr. GINGREY. Well, let me interrupt you for just a second and thank you for that answer. I have been chiefly concerned about the effects of the age band compression provisions on these young people we are talking about, and as you know, the 3-to-1 rating does not reflect the true difference in cost of care. You are an actuary. Right now, 42 States have age rating bans of 5-to-1 or more.

Do you think that a federally directed age band is the best way to direct costs or should the States themselves be allowed the option to make actuarially accurate age band laws, and I say that because I feel very strongly that the States should be able to do that, and that is what this bill, the Liberty Act, Letting Insurance Benefit Everyone Regardless of Their Youth is the acronym to—if the States don't go and deal with this, then the default should be 5-to-1.

If you—Mr. Chairman, if you will bear with me and let the gentleman answer that question.

Mr. CARLSON. I can't comment specifically on the policy of whether we should allow States to set their own limitations, but I will say that if States are allowed to use the 5-to-1 age rate and as many of them do now, you know, the results of our study would be in effect reversed to say that the rates for the younger individuals would be significantly less.

Mr. GINGREY. And Mr. Chairman, this is a bipartisan bill. I would like to again urge my colleagues to sign on to it. It solves the problem, and I yield back.

Mr. BURGESS. The gentleman's time has expired.

The chair recognizes the gentleman from North Carolina, Mr. Butterfield, 5 minutes for questions, sir.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, and thank the three witnesses for their testimony today. Today we have another hearing, "Impact of Obamacare on America's Health Insurance Premiums."

The title makes a lot of sense, Mr. Chairman, if we are talking about how Obamacare brings down the affordable premiums that millions of Americans faced before the Affordable Care Act, but trying to sell us the story that banning insurance company discrimination and creating a free and fair marketplace will raise premiums, that is just wrong.

Now, let's just take a look at a story that will not be uncommon in my district or most districts across the country. Let's say a 35-year-old single man who doesn't smoke and is just above the poverty line, making about $12,000, that is 1,000 bucks a month, $12,000 a year, he doesn't have much savings and any medical bills would put him in real trouble.

Before Obamacare, that constituent could have gone online and found a plan from a big insurance company that cost him $1,400 a year and had a $10,000 deductible and he would have to pay 30 percent coinsurance on every dollar of medical care he received.

But now let's look at the options after Obamacare. If the Governor of my State had been wise enough to expand Medicaid and the legislature wise enough to expand Medicaid, the constituent would have had the option of Medicaid, but on the exchange, the

constituent will get a tax credit to keep his premiums at about 2 percent of his income, which means he will pay $250 a year instead of the $1,400 he would pay for the current plan. He would also be eligible for cost sharing subsidies that will cut his out-of-pocket spending to around $2,000.

So what does that mean? Instead of paying more than $1,400 in premiums, a $10,000 deductible and 30 percent of all costs, the constituent will see his premiums drop to about $250 a year and he will have a real quality insurance that caps his out-of-pocket spending around $2,000.

Now, that is a real savings. And so that is my lead up to my question, Mr. Potter. Let me ask you about this. This constituent that I have been using as a hypothetical will be paying a lot less for coverage under Obamacare, but even if another plan out there offered lower premiums, would it really offer dependable coverage of the way plans will under the Affordable Care Act?

Mr. POTTER. The Affordable Care Act is really important to make sure that people are getting, again, value more than they are today. I mean, we need to, as we are looking at this, to understand that when we are talking about the cost of insurance, we also—and the cost of care, we have to go beyond just looking at the cost of premiums, too. We have to look at what people's obligations are to pay out of pocket, and so there are limitations in the law that would make these $50,000 family deductible plans a thing of the past.

And you are right about your individual that you are using as an example, that that individual would be paying less. And also, frankly, most of the people in this that we are talking about, the young people will also be getting benefits and not be facing these increases unless, for some reason, insurance companies decide and can get away with the price gouging that they seem to be intending to get away with, but most young people will get—either they will be eligible for the Medicaid program or subsidies because most of these folks have relatively lower income.

Another thing to keep in mind, too, is that young people don't necessarily want to be uninsured. Many of them don't have coverage now because they haven't been able to afford it. This law will enable many of those people to come into coverage for the first time, so they will be able to get coverage. It is not that they want to remain naked as they say in the insurance industry or consider themselves young invincibles necessarily. They want to get coverage, and I can also say, guarantee you this, the insurance companies will be spending a lot of money marketing to attract young people. That is where you will see, when the advertising starts, that is a target market they are going to go after to make sure that they sign up for policies.

Mr. BUTTERFIELD. So not only does this guy save money on front end, he saves money on back end with co-pays and all of the other stuff.

Mr. POTTER. That is correct.

Mr. BUTTERFIELD. Well, thank you, and thank all of three of you. I yield back, Mr. Chairman.

Mr. BURGESS. The gentleman yields back.

The chair recognizes Mr. Griffith from Virginia 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman.

In keeping with what Mr. Shimkus said in regard to, you know, we are trying to figure out, since we didn't have hearings before, trying to figure out now where the problems are and where we can fix things. I have been brought to my attention by a constituent at a Farm Bureau dinner that his daughter had a serious problem and it was brought on in part by Obamacare.

She is living at home and is a full-time student, but because she is an industrious young lady, she is also a full-time employee. So she is carrying a full load in college, she is paying for her own way, she is a full-time employee, and because of that she is not eligible to stay on her parent's insurance because there is insurance offered through her employment, which she would be able to stay on her parent's insurance as a part of the family plan at no cost to herself because they are already paying for mom, dad and other siblings, but it will cost her, and I don't remember the exact dollar amount, but I recall it being in excess of several hundred dollars per person, or excuse me, per this young lady, it is going to cost her per month and is of great expense to her, and so I guess I would ask you, Mr. Carlson, have you heard of similar incidences where, you know, the best intentions of the Obamacare or PPACA plan have actually led to, in this case, this young lady having to spend a lot more money in order to be insured because she is out working hard, going to school and living at home?

Mr. CARLSON. Well, I am not aware of any specific instances, but what you are describing there certainly is a case that would sound like it makes sense to me and is possible.

Mr. GRIFFITH. Yes. And you know, we are just trying to figure out where the problems are, and one of the real concerns, and I will turn to you, Mr. Holtz-Eakin, is—and Mr. Lance referenced it earlier. The Washington Post recently reported that they are not being—a lot of these folks with pre-existing medical problems are going to be blocked from the program that was designed to help them, and particularly the Post story highlighted the plight of a 60-year-old Virginia woman who wished to only be known as Joyce who is battling Stage IV breast cancer, and because she didn't know earlier that the plan was available for pre-existing conditions and a high risk or high expense, she was trying to fill her paperwork out when she discovered that there was a new deadline that had been applied, and, you know, the question is, are we making promises we can't fulfill when we say we are going to cover everybody, and then this lady at the time was swinging in the balance, they don't know whether she got her application in in time or not, but the Postarticle says they were going to stop taking new applications no later than March 2nd, and I contrast that with the fact that the House Republicans had a plan at the time of the passage of this bill that would fully fund high risk pools to ensure Americans got the treatment that they needed.

Now, I guess my question is, if we don't have the money currently to take care of these high risk individuals with pre-existing conditions, such as this lady who wished to be known as Joyce, do you believe that we should divert funding from other parts of the

so-called Affordable Care Act towards these high risk pools that offset the cost of coverage for chronically ill so that we can actually address the real problems that have been existed in our health care system?

Mr. HOLTZ-EAKIN. I certainly believe that this story, while tragic, is hardly a surprise. From the beginning I have been concerned about the design of the high risk pools. There were incentives for people to go uninsured, believe it or not, before they could be eligible to come in these pools. They operated side by side with State pools that were often much better designed and got better enrollment, and now they have stopped enrollments entirely. So, obviously there needs to be both a redesign in the criteria for eligibility in the way that the pools are offered, but also the funding, and getting funding out of elsewhere in this law I think would be a sensible thing to do.

Mr. GRIFFITH. And also, I would have to say that if this funding mechanism didn't work as it was promised to work and it that didn't have the ability to follow through because they are running out of funding, we also saw the long-term care insurance didn't work exactly the way they thought it was going to. They never got it off the ground because of that, which I appreciate pulling the plug when it wasn't going to work. Doesn't that call into question for both you and for just the average human being that if two high profile parts of the plan didn't fit in the model that they said it was going to fit, that the entire PPACA plan is probably going to cost us a lot more money than what the American people were told when it was passed?

Mr. HOLTZ-EAKIN. I think that is right. I mean, there are two perspectives on that. The first is the notion of fulfilling the promise of affordable care, and here the fundamental problem has not changed. Americans spend not quite 20 cents out of every national dollar on health care, the Affordable Care Act defines affordable as 10 percent of your income, which means, by definition, not all of us can have affordable health care, and the only way to get people under 10 percent is to raise someone else's cost up perhaps a lot, and that is done through a variety of taxes, mandates, premium increases, and the law will never add up for everybody in the United States. It cannot.

The budgetary costs are extraordinary, and my fear is that it will vastly outstrip the resources that have been devoted to it, particularly if employers follow their incentives and put many more people in the exchanges and higher premiums than we anticipated.

Mr. GRIFFITH. Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. Gentleman's time has expired.

The chair recognizes the gentleman from New York, Mr. Engel, for 5 minutes for questions, sir.

Mr. ENGEL. Thank you very much, Mr. Chairman, and thank you for holding today's hearing, Mrs. Capps as well.

Mr. Potter's testimony is an excellent reminder of the terrible practices routinely employed by the private health insurance industry prior to the passage of the Affordable Care Act. Denying children with pre-existing conditions health insurance policies, canceling coverage for people once they became ill, applying lifetime

limits to care, these practices were commonplace in the individual insurance marketplace before we passed the law.

There were terms we legislators have all used countless times over the last several years, but Mr. Potter's testimony which I read, reminds us these things were done to people. Our constituents, they needed health care and they were denied and some of them died because of it.

Their stories are a sad reminder. It is unacceptable to return to the status quo of the private health insurance industry by repealing the Affordable Care Act, and I wanted to say that before I asked my question.

Now, let me ask this. Private insurance companies have been interested less in insuring those who might actually need care, instead have worked hard to insure the healthiest and least likely to incur major medical expenses and that is why I supported a public option in the Affordable Care Act, but unfortunately we weren't able to get it through, but for my way of thinking, we wanted to ensure that those who were ill or one of the estimated 129 million Americans with pre-existing conditions, that they have health care coverage.

In the absence of a public option, I am very pleased that the strict consumer protection found in this law will be fully implemented by next year. So, Mr. Potter, as someone who has worked in the health insurance industry, do you believe any of the consumer protections, including the age rating requirements as outlined by the ACA, should be changed?

Mr. POTTER. I do not. They are very important consumer protections and they need to stay in place. They need to be implemented. The insurance companies can accommodate. The law will change the culture of the insurance business for the better.

One of the objectives of the Affordable Care Act is to try to get us to a fairer system. The United States certainly has some of the best health care facilities in the world, some of the best doctors in the world. I don't think anyone would dispute that. The problem we have is access to those great facilities and those good doctors. We have one of the most inequitable health care systems on the planet. We rank below Bangladesh when it comes to fairness.

So we need to change that. That is one of the objectives here, and end some of these discriminatory practices that have been prevalent in the industry for many, many years that have led to situations in which people, when they get sick, just can't get coverage, and that could be every one of us in this room or someone we know. We need to keep that in mind.

Mr. ENGEL. Thank you. Let me also say that I am glad that the ACA included rate review requirements for those companies looking to raise their rates by more than 10 percent. I think it is worth noting that since the rate review provisions went into effect, the proportion of proposed rate increases, over 10 percent declined from 75 percent in 2010, to 34 percent in 2012, to less than 15 percent so far in 2013. And I am also pleased that the law established clear medical loss ratio, MLR requirements which have resulted in $1.1 billion being returned to 13 million Americans.

So, let me ask you, Mr. Potter, I believe the combination of these two provisions are helpful for health premium pricing trans-

parency. Are there additional steps that Congress should take to better ensure significant portion of patients' premium dollars being used to in medical care and not PR campaigns like the ones you discuss in your written testimony?

Mr. POTTER. I think even more transparency is in order. It is a very good start but to be able to know how these companies spend our premium dollars. Pardon me. When the individual mandate becomes effective, we are going to be, as you said, we don't have the option of enrolling in a public option. We will have to be buying coverage from private insurance companies. We ought to know a heck of a lot more about how those companies are spending our premium dollars, so even greater transparency, in my view, greater granularity about where our premium dollars are going would be something I think that this committee might want to look into.

Mr. ENGEL. Well, thank you very much, and let me say in conclusion that status quo of health insurance plans before the ACA, as far as I am concerned, was unacceptable, and therefore, I think when we analyze any impact on premiums, it should a true apples-to-apples comparison fully taking into consideration the quality and comprehensive nature of plans as well as taking into account the availability of subsidies for those making below 400 percent of the Federal poverty level.

I thank you, Mr. Chairman. I yield back.

Mr. BURGESS. The gentleman's time has expired.

The chair recognizes the gentlewoman from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. And thank you to our panel.

Mr. Potter, my line of questioning is for you. Are you a health care professional?

Mr. POTTER. I have been. I am not now.

Mrs. ELLMERS. You were. What was your level? What was your title?

Mr. POTTER. I was vice president of corporate communications for CIGNA Corporation. Before that I was with Humana.

Mrs. ELLMERS. Are you a physician?

Mr. POTTER. No, ma'am.

Mrs. ELLMERS. Are you a nurse?

Mr. POTTER. I am not.

Mrs. ELLMERS. OK. So you don't—actually, you have not earned a degree in any type of health care profession?

Mrs. ELLMERS. That is correct.

Mrs. ELLMERS. OK. Well, I am a nurse, OK, I have been for over 21 years. And I want to go to your example, Ms. Leslie Elder, because I, too, have a mother and—had a mother, my mother died at age 73. How old was Mrs. Elder when she died?

Mr. POTTER. Sixty-three.

Mrs. ELLMERS. She was 63. And you had mentioned that she had a treatable—chronic but treatable condition and then I think later you mentioned that she had breast cancer.

Mr. POTTER. She did.

Mrs. ELLMERS. And that she had died of breast cancer.

Mr. POTTER. She died of Hodgkin's lymphoma, as I recall.

Mrs. ELLMERS. So she had cancer, a form of cancer.

Mr. POTTER. That is correct.

Mrs. ELLMERS. Now, I am assuming that she had gotten a diagnosis. She didn't have health care insurance prior to this point?

Mr. POTTER. What happened is her husband is a small—was a small business person. He owned an auto repair business.

Mrs. ELLMERS. Did she have—yes or no, did she have health care insurance at the time of her diagnosis?

Mr. POTTER. She did when she was first diagnosed, but after she was—after her initial treatment, the insurance companies raised their rates on the policy, so they had drop to it.

Mrs. ELLMERS. I had the opportunity very recently to actually visit the cancer center in my hometown of Dunn, North Carolina, and I actually had this very conversation with them. They are doing excellent work.

And one of the things that I wanted to clarify was that what happens with someone who gets a diagnosis of cancer if they are not insured, you know, where does that go and unable to work. And, you know, oddly enough, Medicare disability is something that they can receive.

Now, you mentioned also high risk pools and that they—that she and her husband were not aware of that; is that correct?

Mr. POTTER. That is correct.

Mrs. ELLMERS. And you also mentioned that this was something that she was receiving treatment. Now, it is curious to me as to how she could have been receiving treatment and yet not know about high risk pools and also not know about the possibility of being put on Medicare.

Mr. POTTER. The high risk pool was eligible for her toward the end of her life. She was diagnosed with breast cancer earlier.

Mrs. ELLMERS. OK. When was she diagnosed with breast cancer?

Mr. POTTER. I don't know the exact year. I think it was around 2002 or something like that.

Mrs. ELLMERS. And she died?

Mr. POTTER. She died last summer.

Mrs. ELLMERS. OK. So she actually had—I mean, she—her—she lives——

Mr. POTTER. She had a pre-existing condition, that is right, and that is why their premiums went up so much that they had to drop it because they couldn't afford it.

Mrs. ELLMERS. But the availability to get coverage after that was there.

Mr. POTTER. Ultimately it was.

Mrs. ELLMERS. And they did not take part in it.

Mr. POTTER. They didn't know about it, that is correct.

Mrs. ELLMERS. They didn't know because the health care providers did not—I mean, you know, we have discharge planners, we have social services, we have physicians, we have nurses that are giving treatment. I have a hard time believing that this was all taking place and that they did not understand this.

Mr. POTTER. Well, Congresswoman, I would suggest you might talk to Mr. Elder and ask him these questions. I don't know, but I am told——

Mrs. ELLMERS. And you mentioned the daughter and that the daughter said, and if I can quote you, that if she felt that if

Obamacare had been in place, that her mother would not have died; is that correct?

Mr. POTTER. That is correct.

Mrs. ELLMERS. Do you have a mother?

Mr. POTTER. I certainly do, and she is 88 years old.

Mrs. ELLMERS. And you would like to see her live a good long life, wouldn't you?

Mr. POTTER. And she has. I have been very blessed.

Mrs. ELLMERS. And that is a blessing. And again, my mother died at age 73, unfortunately. She had Alzheimer's, but she also received very good care, excellent care because she had very good coverage. She was also on Medicare, but she still died, and that is a loss, and I understand that Ms. Elders' family is experiencing a loss as well, but I find it curious that you used her as an example of why Obamacare would be such a good plan to be put in place and that somehow this would have saved her. Is that not what you are claiming?

Mr. POTTER. The point of telling her story was to point, if you look at the written testimony, that they were priced out of being able to offer coverage.

Mrs. ELLMERS. But there was other coverage that—in fact, and that is understandable. But those of us in health care——

Mr. POTTER. Not during most of the time that was available to her.

Mrs. ELLMERS [continuing]. Understand that these are forms that have needed to be put in place for a long time and we are ready to work on those things for health care solutions; however, there was other availability there, so I just——

Mr. POTTER. Not during most of the time.

Mrs. ELLMERS. I am not quite sure I am understanding.

Mr. POTTER. Not during most of the time, Congresswoman.

Mrs. ELLMERS. Not Medicare?

Mr. POTTER. I can give, if you would like, I can tell you more about their situation so you can get——

Mrs. ELLMERS. Well, no, I don't think we need to do that, and my time has expired, but I find your testimony disingenuous. Thank you, sir.

Mr. BURGESS. And the gentlelady yields back.

And the chair recognizes the ranking member of the subcommittee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. My questions are of Mr. Potter. Insurance warn that if they are allowed to charge seniors only three times more for coverage than they charge younger people rather than five or six or 10 times more, they will substantially increase premiums on young people, and the Urban Institute recently completed an in-depth analysis of age rating in the ACA and determined these insured claims to be unfounded.

I was going to ask unanimous consent if we could enter into the record this study, Mr. Chairman, by the Urban Institute, which I gave you there.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you. So, anyway, this Urban Institute compared the likely results of allowing insurers to charge older Ameri-

cans five times more for coverage rather than only three times more and found that it would, quote, have very little impact on out-of-pocket rates paid by the youngest non-group purchasers once subsidies are taken into account. And the study found that premiums would stay stable for young people because the ACA provides unique coverage options that specifically benefit young Americans. The law provides for a low cost catastrophic health plan that is available only to people under 30 and it requires that it insures, allow adult children to stay on their parents' plan until age 26, a policy that has already extended coverage to more than 3 million young people, and most important in this study was the fact that young people are some of the most likely to benefit from the ACA's Medicaid expansion and premium tax credits.

So, Mr. Potter, were young people served well by the insurance products on the market before reform, or will they be better off because of the ACA's new reforms and consumer protections? And then I would ask if insurers get their ways and change the age rating band, do you think they will stop there or will they push for other changes?

Mr. POTTER. Young people were not well served, have not been well served and were not before the Affordable Care Act was passed. They have not, obviously, had the benefit of getting subsidies or tax credits or the ability to enroll in Medicaid because of, you know, the way that the programs are structured right now. So they are going to be much more advantaged as a result of the full implementation of the law than they have in the past. They will be able to get coverage that is affordable and it is decent. A lot of the policies that insurance companies market to young adults are limited benefit plans or plans with very high deductibles. Young people are not immune from getting seriously ill or injured, so many of them find themselves, if they bought these policies, at great risk of themselves having to file for bankruptcy and their lives being ruined as a consequence.

Mr. PALLONE. Let me ask you another question. The health insurance marketplaces that will come online in a few months time are a key new tool to help consumers and small businesses shop for coverage. They finally make it easy to compare plans, you know, apples to apples, so consumers can purchase dependable quality coverage. Plans will be forced to compete on price and quality, they provide one-stop shop, reduce transaction costs, increase transparencies. The CBO estimates that these factors alone will drive premiums down 7 to 10 percent and there is a potential for much more savings.

I know my Republicans friends like to talk about how the application for premium tax credits will be too long and complicated, but have they looked at insurance company paperwork recently? The ACA eliminates the fine print loopholes that insurers would hide in their 100-page contracts and said it guarantees quality coverage and requires plans to provide a four-page plain language summary of benefits and coverage.

So, Mr. Potter, when you worked in the insurance industry, would you say the industry was transparent and consumer friendly, and what do you think reforms like those in the new health insurance marketplaces will do to consumer costs?

Mr. POTTER. Insurance companies were anything but transparent and forthcoming in the information that they were providing to prospective customers. There was nothing like what has to be available now. You can now make some apples-to-apples comparisons among policies. You could not do that, and you hardly could be able to decipher information except the slick marketing materials you would get from insurance companies, but now, as you noted, they have to have summaries that are——

Mr. PALLONE. When you say now, you mean with the ACA?

Mr. POTTER. With the ACA, that is right.

Mr. PALLONE. You know, I mean, look, my own experience, you know, I understand what you are saying, and I really want to emphasize that, you know, part of what the ACA is trying to accomplish is to basically make it easier, you know, with the exchanges that you can actually figure out what is going on.

Mr. POTTER. You can.

Mr. PALLONE. And simplify it. And if you want to just comment on that again.

Mr. POTTER. You can be a much better informed consumer now than you ever had been in the past by coverage from insurance companies because they do have to be more transparent, they have to give you some understanding or better understanding of exactly what they will cover and what you might be having to expect in terms of out-of-pocket expenses if you enroll in one plan versus another.

And you can do that online. In fact, you can get that kind of information now because that kind of transparency was required as of the first of this year. So, again, I said earlier that these changes are going to be changing the culture of insurance companies in the industry and for the better, and one of the ways that it is changing these in the culture is through this greater transparency, which by the way, the insurance industry fought. They did not want to do this because they have benefited significantly over the years from keeping us in the dark.

Mr. BURGESS. OK.

Mr. POTTER. They were buying things that weren't necessarily to our best advantage.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. BURGESS. We have a lot of members who are ready to question before votes, so the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions, please.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much, and I thank the panel for their testimony today.

Mr. Carlson, as we discussed earlier, how the $100 billion, at least $100 billion tax on health insurance will drive premiums higher, and I know that you have analyzed the tax's cumulative impact in depth. Can you explain what it means when you say that the Affordable Care Act constructed this tax to be non-deductible and why is it a non-standard treatment of taxes?

Mr. CARLSON. Well, in very simple terms, the tax is not considered an expense in the, you know, in an income statement, so it won't be charged against the company until, you know, after their taxes are taken out of their income or what the profitability is. So, in effect, that means that not only do they have to fund the tax,

but they also need to fund an additional amount to reflect the taxes that they will have to pay on that. So, you know, as Dr. Holtz-Eakin said earlier, you know, you have to collect $1.50 in premium in order to pay the dollar of the insurer fees.

Mr. BILIRAKIS. Thank you. Again, Mr. Holtz-Eakin and Mr. Carlson, the tax on health insurance is one of many factors that will cause premiums to rise. I think we have established that there is a real threat that small employers will be forced to terminate employee coverage and send their workers to the exchange subsidized coverage.

What will the repercussions be if this happens, and if both of you can give me an answer, I would appreciate it.

Mr. HOLTZ-EAKIN. Well, certainly, if you do the arithmetic for any employer whose employees are under 3 percent of the Federal poverty line, it is a no-brainer to stop offering insurance, send individuals to the exchanges. You can give them a raise. They can use the after tax raise and subsidies to buy better insurance than you could offer them. You can pay a penalty on top of that and still make more money.

And so there are overwhelming economic incentives for a vast numberof employees then after the exchanges. The implications of that, I think, are pretty straightforward. Number one, the Federal budget cost is going to be radically higher than it has been estimated to date.

Number two, if in fact we see the premiums increase at the same time, those subsidies will increase per person, so again we get a second hit on the budget cost. This will change the provider networks that many of these individuals will be accessing so they will get disruptions in their care, and the labor market turmoil, I think, will be substantial, and we are beginning to see that with the large number of employers who are moving people to part-time status instead of full-time in order to accommodate the mandate. It is just one of the many potential labor market manifestations of the big implications of this law.

Mr. BILIRAKIS. Thank you. Mr. Carlson?

Mr. CARLSON. Yes. And I will just add the $8 billion that starts in 2014, it is a fixed number. So if the pool of fully insured premiums that that amount is charged against goes down, in effect the rate will go up. So if you look at our study we have a high estimate and a low estimate, and the high estimate for the percentage is based on the assumption that employers, especially in the small group market, will drop their coverage and put their employees out into buying in an exchange or other alternatives. So we relied upon industry studies which in fact said that is a possibility going forward. So the more employers that drop their coverage from the fully insured market, the more likely it is that that premium rate increase will continue to go up further.

Mr. BILIRAKIS. Thank you. Mr. Chairman, I yield back. I appreciate it.

Mr. BURGESS. The gentleman yields back.

The chair recognizes the gentlelady from Tennessee, Mrs. Blackburn, for 5 minutes for questions, please.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you for being with us today. We appreciate this.

Mr. Potter, I want to be sure I understood you right. You said that we were charging people so much for health insurance that they couldn't afford to buy it before. You made that as a statement that took place before Obamacare. People were being charged so much that they couldn't afford to buy health insurance.

Did I understand you right on that?

Mr. POTTER. You are right, Congresswoman.

Mrs. BLACKBURN. Let me ask you this then. I have some stats from people in my district of how their health insurance premiums have gone up since the passage of Obamacare, and I want to just read through these. I have a car dealership down in Fayetteville. They dropped coverage because the increase was so much. An insulation company with 36 employees in Nashville, they dropped it due a multiple year large rate increase and administrative burdens on their plan. A consulting firm with two employees, a 56 percent rate increase in 2013, and that followed a 15 percent in 2012. A restaurant over in Springfield, employees no longer allowed to work more than 29 hours a week. That is a jobs program for you, isn't it?

An auto parts company over in La Vergne, they had had a management carve-out, but let's see, a 30 percent increase last year, not going to be able to offer coverage to everyone that works 30 hours or more a week. I mean the list goes on and on. We have got a flooring company with 30 employees, a 21 percent increase, and a law firm with three employees, a 16 percent increase this year, 38.5 percent last year. A physician's office, seven employees, a 21 percent increase. A commercial printing company, 25 percent increase. A manufacturer with six employees, a 25 percent increase. A construction company with nine employees, 15 percent increase this year followed on top of a 42.5 percent increase last year. Oh, here is a private school with 68 employees, a 17 percent increase, and a retail flooring store with five employees, they had a 123.27 percent increase that is taking place next month.

Sir, what do you tell these employers who are trying to do the right thing? You thought health insurance was expensive before, but what do you tell them now, it is exorbitant?

Mr. POTTER. I might tell them the story of Jim and Leslie Elder, and I don't think it is disingenuous.

Mrs. BLACKBURN. No, we are not going to go there. You have sat there and told that story over and over and over. And I have great compassion——

Mr. POTTER. Because it is an important story. And I am from the Great State of Tennessee and my mother gave——

Mrs. BLACKBURN. No, sir, it is my time and we are not going to tell it again. I have great compassion for anyone whole loses a parent through such a situation. I have just lost my father and I understand what people go through. But I have got to tell you something right now, I think that what we have to do is look at what is happening to these insurance costs.

And here is one I have got. You know, these are all in my district. These are real live numbers that are coming back in. I can tell you something right now. Have you ever heard of TennCare?

Mr. POTTER. I have.

Mrs. BLACKBURN. OK. We had that in Tennessee and you know what happened there, don't you? It was a disaster. It was such a disaster that a Tennessee Governor, a Democrat Governor, had to go in and completely reshape the program.

And let me ask you this. Have you ever heard of any, is there any public option health care program that you can point me to that actually saved money and increased access?

Mr. POTTER. Public option? We don't have any public options in this country.

Mrs. BLACKBURN. Oh, that is not what you call TennCare. It was a test case for Hillary Clinton's health care. Well then, let me ask you this about guaranteed issue. Right here, I have got in '93 a 30-year-old woman in New York had an average premium, let's see, of $1,800 a month. New York passed guaranteed issue and community rating, and guess what that premium went to? $3,240. So you go from $1,800 to $3,240. That is a $1,400 a year increase after you insert government control. So if we don't have public option, then have you ever seen a government-run health care system that has increased outcomes, decreased costs and increased access?

Mr. POTTER. Many systems around the world have done a much better job of increasing access and controlling costs.

Mrs. BLACKBURN. My time is about up. Mr. Holtz-Eakin, are there any examples you can point to there that have lived up to promises?

Mr. HOLTZ-EAKIN. There are no U.S. examples of that type, ma'am.

Mrs. BLACKBURN. Mr. Carlson?

Mr. CARLSON. I have none.

Mrs. BLACKBURN. You have none. I yield back.

Mr. BURGESS. The gentleman's lady time has expired.

The chair recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for your questions, please, sir.

Mr. GUTHRIE. Thank you very much. I thank the panel for being here. I would like to build on what some of my colleagues have talked about today and deep concerns over the rising cost of health insurance.

The President when he was pushing the health care law said it would reduce premiums on a family of four by $2,500, and we have now seen it has increased by 3,000 per year and the most expensive portions of the law haven't been put into place, has not gone into effect yet, I should say.

I come from Kentucky and in the early 1990s we actually were trying to be, before Tennessee, to try to set the standard. In the 1990s our entire insurance market collapsed in Kentucky. We attempted a guaranteed issue, guaranteed portability, modified community rating. Immediately like half our insurance providers left. We were down to one. We had to go back and redo the whole law just to get—individuals were completely wiped out of the market. Most companies went self-insured just so they could provide health insurance to their employees who couldn't afford it. They had to be in the ERISA category instead of the other category. And I would like to think that Kentucky just wasn't isolated. I think we just heard from Tennessee's example and one from New York that my friend brought up.

Dr. Holtz-Eakin, Kentucky, Tennessee, are they the only examples?

Mr. HOLTZ-EAKIN. There are numerous other examples, the State of New York, the State of New Jersey. You can go around the country and look at Kentucky, Vermont, Washington State, all of whom experimented with this and had big premium problems, and in some cases, such as Kentucky, reversed course, having gone through it.

Mr. GUTHRIE. We had to. You couldn't get insurance. None would even offer it, much less pay the price that it cost. So we have been there and it didn't work, and now we are trying to do this on a Federal level. And I believe even Jerry Brown, the Governor of California in his state of the budget, so it is not a Republican sitting here trying to say this is an issue. Jerry Brown, I don't think anybody would call him a Republican or a conservative, said in his state of the budget that large rate increases in individual markets are likely, and that is when he put in when he accounted for his budget.

So the way groups will react to the market is something, Dr. Holtz-Eakin, that I am interested in. There is an Oliver Wyman study from 2009 that highlights some significant red flags about the impact of the health care law, and one of the few things is as the prices rise, obviously less healthy people have to maintain coverage and they are least likely to drop coverage even if they absorb the cost because they are less healthy. So then healthy individuals are least likely.

I used to say that the only person, a healthy young person over 26 that will have insurance in America, are people who just want to abide by the law because there is no financial incentive to do it because you have guaranteed issue. Then it changed. The law was rewritten by the Supreme Court, as you know, so you are not even violating the by not violating health insurance, you are paying a tax in lieu of health insurance. So there is no penalty any more. That was changed by the Roberts court.

But I don't see how premiums won't spiral. The whole concept, Dr. Holtz-Eakin, and I will give you the remainder to talk on this, is you bring young people into the market by mandating coverage and by younger healthier people in the market it brings down the premiums for everybody. You are sharing the risk. But then there is not a financial incentive at all or even a health incentive because of the guaranteed issue for a young person to enter the market. And they are not even mandated to do any more. They can pay a tax in lieu of going into the market. So can you just comment on how that is going to affect premiums, this premium spiral I am getting at.

Mr. HOLTZ-EAKIN. This is a serious issue. The whole notion is that you have a base level of premium cost that comes from the cost of health care and there is no way to change that with the insurance provisions. And then you want to have a large risk pool to take that national health care bill and distribute it across people. The experience in States has been one in which the combination of guaranteed issue-community rating caused the healthy to opt out, and in some cases it led to insurance state pool death spirals, the

continuing higher premiums, people leave. And that has been the concern about the construct in the Affordable Care Act.

Massachusetts has a—that is a similar design and it has now been widely noted that costs have continued to go up there and we are now seeing individuals hop in and out of coverage. The mandate is not working, and I am worried about this.

Mr. GUTHRIE. Mr. Potter, do you see the construct of the law, the premium spiral, you don't see this as a threat? The construct of the law for young people to buy health insurance, the incentive is not there for them to buy health insurance. Do you think young people are going to opt out of the market and the premiums are going to go up? You don't think that is a real concern?

Mr. POTTER. I think what the real experience is we can speculate, but I think that, as we said before, young people will benefit from being able to get subsidies. They want to have coverage. I think most people will be wanting to enroll in a benefit plan.

Mr. GUTHRIE. With guaranteed issue?

Mr. POTTER. If there is guaranteed issue and a requirement to purchase. The thing that you have to keep in mind is that in some of the States you talked about, if you have guaranteed issue without any kind of a mandate, which is why the Affordable Care Act was developed as it was——

Mr. GUTHRIE. But the mandate, you can pay a small tax in lieu of paying a premium.

Mr. POTTER. We can argue as to whether or not it is an enforceable or a large enough mandate.

Mr. GUTHRIE. If it is not enforceable, they are not going to be in the system. That is the point.

Mr. POTTER. Again, I will say most people want to be covered. It is not that they want to go without——

Mr. GUTHRIE. As prices rise and they can get it when they need it, why would you pay for it if you can get it when you need it, as prices rise.

Mr. POTTER. Because you don't know when you going to need it. I might get sick tomorrow or my son might. My son is not an idiot. He will want to have coverage because he knows that he might get injured. I think most young people realize that they are not bulletproof. They will be getting coverage because they know things like that happen to people.

Mr. BURGESS. The gentleman's time has expired. I appreciate the attendance of everyone who has been at this subcommittee. It has been a good attendance. The ranking member and I will offer one last question to the panel. I recognize the gentleman from New Jersey for 5 minutes.

Mr. PALLONE. Thank you, Chairman.

My colleague asked if we know of any public health care system that improved outcomes and controlled costs, and I will certainly give you one, and that is Medicare. It has lower administrative costs than private insurance and it provides great coverage, in my opinion.

But I wanted to ask Mr. Potter a question. Opponents of guaranteed issue have tried to compare the ACA's guaranteed issue requirement to previous State experiments of guaranteed issue and I think this is very misleading. The ACA contains significant pre-

mium subsidies and responsibility requirements for individuals and employers. By expanding the pool of who gets covered, the costs increases that critics have tried to associate with the ACA disappear.

Massachusetts health reform is probably an appropriate example. In 2006 when it enacted its comprehensive health reform, Massachusetts already had guaranteed issue in place. When the State enacted health reform similar to the ACA, premiums in the State's individual market fell by 40 percent while they rose by 14 percent nationwide.

So, Mr. Potter, requiring that insurance companies provide coverage to all who apply represents a big change to these companies' business models, isn't that correct?

Mr. POTTER. That is absolutely correct. Most of them these days, their business models are based on underwriting and being able to try to cherry pick and exclude as many people from coverage as possible.

Mr. PALLONE. So do you think there is any comparison between the rise in premiums in States that required guaranteed issue in the nineties and the comprehensive nationwide reforms representing by the ACA?

Mr. POTTER. What the ACA does, Congressman, is taking an approach that is different from what some of the other States took and made the circumstances in those States different from what they will be with the implementation of the Affordable Care Act.

Mr. PALLONE. Do you want to just elaborate on that a little more?

Mr. POTTER. Again, if you have a mandate without—I mean if you have guaranteed issue without incentives to purchase insurance or without a requirement, then there will be people who will opt out, and that does increase the cost of coverage, and that is why the Affordable Care Act was constructed as it is, to make sure that more people will have that incentive to purchase insurance.

Mr. PALLONE. Let me ask you one more thing. Opponents of the ACA are attempting to spread fear that the law is going to increase costs for millions of Americans. However, the CBO and other analysis have shown that this notion of market-wide premium increases is simply a myth. First of all, 95 percent of the insured population in this country has either public coverage or employer insurance, and that is over 240 million people. Every objective analyst agrees that employer coverage will not become significantly more costly under health reform and a recent study found that increased employer costs associated with health reform were equal to.0003 percent of wages, which is simply too small to legitimately lead to large premium increases. Even the faulty Republican studies discussed today agree that only a subset of that remaining 5 percent of the market even has the potential to see a premium increase under health reform.

So, Mr. Potter, you worked on messaging and public relations at insurance companies. Does it surprise you that this attention and fear mongering is occurring over such a small segment of the marketplace and was the individual market before reform a profitable sector for insurance companies?

Mr. POTTER. It doesn't surprise me at all, because it is just a continuation of the same kind of tactics they have used a lot and that

I have written about quite a bit. So what they want to do is create an impression of something that is bigger than it is or even will exist and it might not. So it is exactly what they have done in the past. And the marketplace will change significantly, these companies will change a great deal as well as a result of this, and I think we will be seeing that coverage will become more affordable.

Your point is very well taken, too. It doesn't apply. The vast majority of people in this country, if they get coverage through the workplace or through a public program, will not see the—they are not in the individual market, so the effects will be very limited.

Mr. PALLONE. All right. Thank you. Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman yields back his time.

Mr. Carlson, you are the numbers guy, so very quickly, in your experience has there been any industry where the industry has been force-fed Federal dollars that results in lower costs to consumers at the other end?

Mr. CARLSON. Not that I am aware of.

Mr. BURGESS. Student loans come to mind, don't they, and then some of the problems with the bubble in the housing industry. Force feeding Federal dollars into an industry actually can be quite deleterious, although it seems like it is a compassionate and good thing to do.

Mr. Potter, I just have to say I am so grateful that the gentlelady from North Carolina posed the questions to you that she did. I must say I was reading the testimony last night and I thought this just doesn't sound like reality. I practiced medicine for almost 28 years, Parkland Hospital, Texas Medical Center, over 20 years in private practice in North Dallas. I cannot—I mean, you are an insurance company. If an insurance company leaves a patient, the doctor, the cancer center, those people don't just turn people away. You may think they do, but they don't. We took care of patients every day who had no realistic means of ever paying their bill. Even if it wasn't altruism involved, there is always the threat of medical liability for abandoning a patient. A family might bring a cause of action.

So I just have been wracking my brain to think of a comparable clinical situation that I encountered in almost 30 years, and there is not one. Ms. Ellmers is exactly right. The cancer centers that I know, they would never turn away a patient. They would find a way to work with them, maybe find a program at the medical school in the center of the State, maybe find a facility like M.D. Anderson Hospital to participate. But you wouldn't just say well, I am so sorry about your financial situation, I hope things work out for you. In reality that just does not happen.

Now, I will say this. You worked for CIGNA. In the late 1990s CIGNA, I think all of the large insurance companies were involved in what were called black box edits; slow pay, no pay, down coding of bundling and lowering reimbursement rates to physicians. The insurance industry during the nineties, I am glad that they are not that way anymore, but they were responsible for some serious stresses on the system, certainly from the perspective of a provider.

In fact, providers, really we could do them a great favor if we would say when you take care of a person who is in this situation where you are not going to be paid, we will allow you a credit to-

wards your taxable income. And those will have to be negotiated rates, but I think there are ways to deal with the problem. There is always going to need to be safety nets. Safety nets are important.

Dr. Holtz-Eakin, this $16.5 trillion debt, that is not just a theory, that is an application, right? And what happens when the music stops? What happens when the administration goes down to the Bureau of Public Debt to peddle paper on a Tuesday at noon and nobody shows up to buy?

Mr. HOLTZ-EAKIN. It is not something you want to contemplate, Congressman.

Mr. BURGESS. Right. The interest rates begin to go upward, and they can go upward in a quite dramatic way. You and I will be inconvenienced. It will cost us more to buy a car or buy a house. People who depend on social safety nets, they are going to be clobbered when that day happens. So it is important when we talk about things in terms of Federal spending and debt, it is not just an esoteric, it is reality that people, no one of us, the President, no one in the Senate, no one in the House of Representatives knows when that day of reckoning is going to occur.

The President came and talked to House Members earlier this week and he said I don't think you all should worry about it so much. That is going to be way in the future. I don't know. I don't have the same confidence that the President has that he can continue to run trillion dollar deficits every year for another 4 years and there is no effect on the larger economy and there is no effect on the dollar being the reserve currency of the world. I think there is going to be an effect.

But I find this hearing fascinating because we are perched on the brink of the final rollout of the Affordable Care Act. It is something that is very difficult to contemplate. I don't think HHS is ready by any stretch of the imagination. You talk about people who are left in the lurch. I think you are going to have a lot of people who go to sign up on their 21 page application on October 2nd or 3rd and find that the system is not ready for them, the system does not work. You can only get one chance to make a first impression.

I wish the agency would be more forthcoming to come to this committee and talk to us about where they are in the construction of the informatics piece, in the development of the Federal exchanges that are going to have to take place because 26 Governors say we don't trust the administration enough to set up a State exchange.

I thank everyone for their forbearance during this hearing. I think it has been a good and informative hearing.

I have a unanimous consent request, Mr. Ranking member, to insert an article from the Boston Herald into the record. The headline is "Mass. individual health premiums highest in the Nation."

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. I remind members they have 10 business days to submit questions for the record and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business Monday, April 1st, and that is no joke.

Without objection, the subcommittee is adjourned.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance

Timely Analysis of Immediate Health Policy Issues
March 2013

Linda J. Blumberg and Matthew Buettgens

Summary

As the 2014 start date for the ACA's full implementation approaches, insurers are calling attention to a potential "rate shock" – or substantial increase in health insurance premiums – that will push young adults out of the nongroup insurance market, leaving them uninsured and raising premiums for older adults. Accordingly, the industry advocates pulling back on the ACA's requirement that premiums for adults age 64 be no more than three times higher than the premium for adults age 21 for the same coverage (a constraint relative to the fivefold-or-more difference that applies in today's market). This paper compares the likely impact of the ACA's 3:1 rate band to a "looser" 5:1 alternative—using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine behavior of likely purchasers. The analysis considers not only the ACA's rating requirements but also the impact of subsidies and Medicaid, CHIP or other coverage that will limit the out-of-pocket health costs individuals and families actually pay.

Overall, we find that loosening the rate bands from 3:1 to 5:1 would have very little impact on out-of-pocket rates paid by the youngest nongroup purchasers, once subsidies are taken into account. This is not only the case for all likely purchasers, but also for two populations of particular concern: the 10 million 21-27 year olds who are currently uninsured and the 3 million who currently have nongroup coverage.

The vast majority of these young adults will be protected by Medicaid/CHIP, subsidies provided through the exchanges, or by their parents' employer-based coverage. By contrast, looser rate bands would significantly increase out-of-pocket rates paid by the oldest purchasers, who lack a parental option and are substantially less likely to be eligible for subsidies.

Introduction

Considerable attention has been given to the possible "rate shock" in nongroup insurance markets once the full reforms associated with the Affordable Care Act (ACA) are implemented in 2014. The insurance industry warns, in particular, that the 3-to-1 age bands included in the law will substantially increase premiums faced by young adults, pushing them out of the insurance market and leaving them uninsured.[1] These age bands constrain carriers from charging a 64-year-old more than three times the premium of a 21-year-old for the same coverage. The industry believes these bands should more closely align with the premium variation by age seen in today's nongroup insurance markets (typically at least 5 to 1).

This paper explores the full distributional implications of the 3:1 bands relative to the "looser" policy alternative of 5:1 bands, and specifically examines what the young adults currently covered through the nongroup insurance market and those uninsured will face once the reforms are fully in place. A complete analysis, such as the one presented here, requires an assessment of how other changes forthcoming in the ACA could also affect this population, including eligibility for tax credits to offset some of the costs of premiums and cost-sharing responsibilities, as well as Medicaid eligibility. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine these issues comprehensively.

Tighter age-rating bands will increase premiums charged for the youngest adults older than 20 and lower them for the oldest adults compared to looser age bands. However, most young adults currently covered by nongroup insurance will be shielded from the full effects of the narrower age-rating bands by the ACA's increased eligibility for Medicaid, the tax credits offered through the health insurance exchanges, or through access to employer-sponsored insurance.

Methods

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.[2] Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model estimates changes

Robert Wood Johnson Foundation

Urban Institute

Table 1: CMS Proposed Standard Age Curve

Age	Premium ratio	Age	Premium ratio	Age	Premium ratio
0–20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64+	3.000

Source: *Federal Register*, vol. 77, no. 227, Monday, November 26, Proposed Rules.

in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We expect that behavioral changes by individuals and employers to the 2014 reforms will have reached equilibrium at most three years after implementation.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,[3] which is referenced in the final rules as well.[4] Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With the 5:1 rating, we followed the same approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the notice of proposed rulemaking.[5] As a result, premiums will vary not only with age, but also by the number of individuals in the family.[6] All individuals are simulated to enroll in ACA-compliant insurance plans.

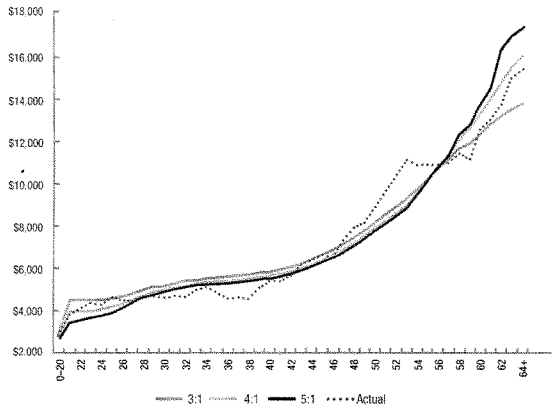
We simulate age-rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant. We also assume a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution. Additional methodological details are provided in the appendix.

Results

Exchange-Based Nongroup Health Insurance Premiums. Figure 1 illustrates the average premium by age for a silver-tier policy under the ACA as simulated in HIPSM using the CMS proposed standard age curve. Silver is the tier to which premium and cost-sharing subsidies in the nongroup health insurance exchange will be calculated. Using a bronze-tier plan would shift all the curves in the figure down; using gold or platinum plans would shift them up. While CMS only delineates the age curve for 3:1 rating since that is the approach required under the ACA, we adapt their gradient for 4:1 and 5:1 age-rating bands by changing the relative differences between age groups proportionately. While the remainder of the analysis focuses exclusively on comparisons of 3:1 and 5:1 ratings, we show 4:1 rating in figure 1 as well in order to clarify its implications relative to the other two, particularly for phasing down from looser to tighter bands as some in the industry have proposed.

The orange line represents the 3:1 premium gradient, the light blue the

Figure 1: Premiums at Different Age Compression Ratios, New HHS Method



4:1 gradient, and the dark blue line the 5:1 gradient. Since family premiums will be constructed in the post-reform nongroup market by summing the age-rated individual premiums of each family member, these curves reflect the age-rated premiums facing all nongroup enrollees expected to purchase coverage in the exchange, whether they would enroll in a single or family policy. By design, there is very little difference between the premium curves under the different age bands except for the youngest and oldest adults. Premiums are noticeably higher for those age 21 to 27 under 3:1 rating and are noticeably lower for those age 57 and older. The difference between premiums charged on behalf of those age 28 to 56 are considerably smaller across the different rating approaches, with the premiums under 3:1 slightly higher than under 4:1 and 5:1.

The red dotted line represents the variation in premiums that would be expected if age rating varied by the average covered expenses of those individuals actually expected to enroll in nongroup coverage under the ACA. The 3:1 age gradient developed by CMS is reasonably consistent with expected enrollee expenses, particularly for those up to age 27 and for those age 42 and older. Using the 5:1 age gradient would tend to undercharge young adults relative to their actual expenses and overcharge older adults relative to their actual expenses.

Table 2 shows the full average premiums for exchange-based nongroup coverage, by policy type (single versus family), and age of those covered for each of the two rating scenarios. The overall averages differ very little (less than 4 percent), due to slight differences in the age and health care risk of the nonelderly population enrolled in nongroup coverage and in the mix of policies purchased across the actuarial value tiers (bronze, silver, gold, and platinum).[7] For family policies, premium differences also reflect family size and age composition variation in those insured across the scenarios.

The largest differences in average single premiums between the age-rating scenarios, as would be expected, occur for adults age 21 to 27 and age 57 and up. Premiums for 21- to 27-year-olds are $850 lower under 5:1 than under 3:1 rating, while premiums for the 57- to 64-year-olds are $1,770 higher under 5:1 bands, on average. Average premiums for 18- to 20-year-olds are $150 lower under 5:1 rating than under 3:1 rating, about a 5 percent difference. Those age 28 to 56 would also see considerably smaller differences in average premiums under the two rating scenarios, in the range of 4 to 5 percent.

Similarly, average family premiums for those with older family members (57 and above) but without members 21 to 27 years old are significantly lower under 3:1 than under 5:1 rating. Conversely, those families with at least one member age 21 to 27 but without members from the older age group would save under 5:1 rating compared to 3:1. However, the savings for the younger units of moving to 5:1 rating would be about half the size of the increased cost that would be imposed on the older families. Differences in premiums across the rating regimes are much smaller for other mixed-age families.

Net Cost to Families, Taking Account of Premiums, Out-of-Pocket Costs, and Subsidies. As noted, premiums alone do not accurately portray the implications of different age-rating bands within the context of the ACA. Health care costs under reform also include out-of-pocket spending (e.g., deductibles, co-insurance), and federal subsidies reduce these costs for those with modest incomes. Table 3 shows the average 2017 health care costs faced by those insured through the nongroup insurance exchanges, by age, policy type, and income group, under the two age-rating band scenarios. For all insureds with incomes between 133 percent and 300 percent of the federal poverty level (FPL), within each age group, there is almost no difference in net costs between scenarios. This

Table 2: Average Premium for Exchange Based Nongroup Health Insurance Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals, 2017

	Premium Rating Option		
Age Group of Policyholder	**3:1**	**5:1**	**Difference**
Single Adults			
18–20	3,050	2,900	-150
21–27	4,850	4,000	-850
28–44	5,840	5,540	-300
45–56	8,930	8,560	-370
57+	13,160	14,930	1,770
Overall	6,930	6,660	-270
Family Units			
At least one age 21–27, none age 57+	11,580	10,340	-1,240
Other mixed-age families	16,200	15,440	-760
At least one age 57+, none age 21–27	23,450	25,930	2,480
Overall	16,970	16,570	-400

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Estimates include portions of premiums paid privately and via federal subsidies.

Table 3: Net Cost to Families for Nongroup Policyholders by Premium Age Rating Option, Age of Covered Individuals, and Income Relative to Poverty, 2017

			Out-of-Pocket Costs by Income		
Age Group Single Units	**Age-rating restriction**	**Covered lives (thousands)**	**133–300% of FPL**	**300–400% of FPL**	**400%+ of FPL**
18–20	3:1	290	$1,390	$4,640	$3,910
	5:1	286	$1,370	$4,560	$3,760
	Difference		*-$20*	*-$80*	*-$150*
21–27	3:1	1,544	$1,530	$4,850	$5,820
	5:1	1,568	$1,530	$4,580	$5,350
	Difference		*$0*	*-$270*	*-$470*
28–44	3:1	1,718	$1,660	$5,030	$6,530
	5:1	1,735	$1,660	$4,920	$6,200
	Difference		*$0*	*-$110*	*-$330*
45–56	3:1	1,329	$1,830	$5,610	$11,360
	5:1	1,347	$1,840	$5,620	$10,860
	Difference		*$10*	*$10*	*-$500*
57+	3:1	718	$2,270	$6,250	$15,620
	5:1	672	$2,260	$6,250	$17,020
	Difference		*-$10*	*$0*	*$1,400*

			Out-of-Pocket Costs by Income		
Age Group Family Units	**Age-rating Restriction**	**Policies (thousands)**	**133–300% of FPL**	**300–400% of FPL**	**400%+ of FPL**
At least one age 21–27, none age 57+	3:1	353	$3,560	$7,770	$12,900
	5:1	369	$3,590	$7,220	$11,670
	Difference		*$30*	*-$550*	*-$1,230*
Other mixed-age families	3:1	2,315	$4,440	$10,030	$21,500
	5:1	2,388	$4,410	$10,000	$20,740
	Difference		*-$30*	*-$30*	*-$760*
At least one age 57+, none age 21–27	3:1	642	$4,730	$9,970	$28,410
	5:1	615	$4,710	$9,970	$30,730
	Difference		*-$20*	*$0*	*$2,320*

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Net cost is premiums plus out-of-pocket costs less subsidies.
FPL = federal poverty level

consistency results from the structure of the federal premium subsidies, which limit the amount of premium owed to a share of family income. The same is largely true for those with incomes between 300 percent and 400 percent of FPL, as this income group is also eligible for federal subsidies.

We do, however, see net costs somewhat lower for the younger adult age groups purchasing policies under the looser rating scenarios. With 3:1 age rating, single premiums for a young adult in this income group are generally greater than the amount they would

Table 4: Number of Policies and Median Health Care Spending Relative to Income for Nongroup Insurance Purchasers by Premium Age-Rating Option, Age of Covered Individuals, and Income Relative to Poverty

		Income Relative to Poverty and Percentile of Financial Burden Distribution					
Age Group Single Units	**Age rating restriction**	**133–300% of FPL**		**300–400% of FPL**		**400%+ of FPL**	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
18–20	3:1	7.2%	233	12.9%	19	5.5%	14
	5:1	7.2%	228	13.0%	20	5.3%	14
	Difference	*0.0%*		*0.1%*		*-0.2%*	
21–27	3:1	7.2%	1,317	11.2%	48	9.6%	64
	5:1	7.2%	1,314	11.1%	42	8.1%	79
	Difference	*0.0%*		*-0.1%*		*-1.5%*	
28–44	3:1	7.2%	1,206	11.3%	49	8.4%	156
	5:1	7.2%	1,207	11.3%	47	8.0%	164
	Difference	*0.0%*		*0.0%*		*-0.4%*	
45–56	3:1	7.8%	875	13.9%	87	12.6%	143
	5:1	7.8%	874	14.2%	86	12.0%	148
	Difference	*0.0%*		*0.3%*		*-0.6%*	
57+	3:1	9.3%	483	18.7%	67	13.9%	86
	5:1	9.3%	485	18.7%	67	16.0%	72
	Difference	*0.0%*		*0.0%*		*2.1%*	
All	3:1	7.5%	4,115	13.2%	270	10.0%	464
	5:1	7.5%	4,108	12.8%	261	9.5%	477
	Difference	*0.0%*		*-0.4%*		*-0.5%*	

		Income Relative to Poverty and Percentile of Financial Burden Distribution					
Age Group Family Units	**Age rating Restriction**	**133–300% of FPL**		**300–400% of FPL**		**400%+ of FPL**	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
At least one age 21–27, none age 57+	3:1	8.4%	299	12.0%	26	14.5%	46
	5:1	8.6%	307	11.9%	28	13.2%	46
	Difference	*0.2%*		*-0.1%*		*-1.3%*	
Other mixed families	3:1	9.8%	1,465	14.2%	257	16.4%	601
	5:1	9.6%	1,461	14.4%	268	16.1%	621
	Difference	*0.0%*		*0.2%*		*-0.3%*	
At least one age 57+, none age 21–27	3:1	14.0%	332	19.4%	78	17.6%	174
	5:1	13.9%	331	19.4%	78	18.8%	153
	Difference	*-0.1%*		*0.0%*		*1.2%*	
All families	3:1	10.0%	2,096	14.7%	361	16.5%	821
	5:1	10.0%	2,099	14.7%	374	16.0%	820
	Difference	*0.0%*		*0.0%*		*-0.5%*	

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Analysis based on the ACA in 2017. Medicare recipients are excluded from the 57+ age group. Significant numbers of adult non-group policyholders age 27 or younger report being students. As a result, some in this age group will be eligible for student insurance through their colleges and universities. It is unclear how many will opt for school-based coverage over exchange-based coverage, so they are all included here. Numbers of single policies equal number of covered lives. More than one person is covered under each family policy. Median health care spending is premiums plus out-of-pocket costs, minus subsidies.
FPL = federal poverty level

be required to contribute toward their coverage; the federal subsidy pays the excess of their premium over 9.5 percent of their income. If age rating is 5:1 instead, premiums for this age group would sometimes be lower than the 9.5 percent of income contribution requirement, in which case the federal subsidy would be $0. These young adults would thus pay modestly less, on average, for single coverage under 5:1 age rating even though they are eligible for subsidies by virtue of their income.

Ninety-two percent of adults age 21 to 27 enrolling in single plans[8] in exchange-based coverage have incomes below 300 percent of FPL—in other words, the vast majority of young adults enrolled in these plans would not face different health care costs regardless of the rating bands chosen because of the protection afforded them by the ACA's subsidies (calculated from number of policies provided in table 4).[9] The same is true for 88 percent of 18- to 20-year-olds, 85 percent of 28- to 44-year-olds, 79 percent of 45- to 56-year-olds and 76 percent of those age 57 and older. Only about 4 percent of the youngest age group purchasing single plans have incomes high enough to make them ineligible for subsidies,[10] compared with about 14 percent of the oldest age group. Over 80 percent of the youngest families buying coverage are eligible for financial assistance for exchange-purchased family coverage.

The largest differences in costs across the age rating scenario are apparent for those with incomes over 400 percent of FPL, those who are ineligible for subsidized coverage. Average net costs for higher-income young adults age 18 to 20 buying single coverage are $150 lower under 5:1 rating than under 3:1, and the cost difference for 21- to 27-year-olds is $470. In contrast, those age 57 and older purchasing single policies would face $1,400 higher average costs under 5:1 age rating than under 3:1 rating. Similar patterns are seen for families with different age compositions. Again, the gains to the young adult families from moving to a 5:1 age rating approach would be half the increased costs imposed on the older families.

Net costs for older adults are considerably higher than for the younger adults, not only because of age rating and its consequent higher premiums, but also because older adults' use of medical care tends to be significantly higher, meaning their out-of-pocket spending is considerably higher as well. Thus, average spending under 3:1 rating by single 21- to 27-year-olds with incomes above 400 percent of FPL is $5,820, while it is $15,620 for singles age 57 and older of the same income. Likewise, average direct costs for older families under 3:1 rating are $28,410 compared with $12,900 for younger families.

Health Care Financial Burdens for Those Purchasing Exchange-Based Nongroup Coverage. Table 4 provides median direct health care expenses relative to income for those buying health insurance coverage through the nongroup exchanges. As indicated by the average expenses shown in table 3, the choice of age bands has almost no effect on the financial burdens of those with incomes at or below 400 percent of FPL, which account for about 85 percent of policies sold through the nongroup exchanges. While higher-income 21- to 27-year-olds buying single coverage would see a 1.5 percentage point higher health care financial burden under 3:1 than under 5:1 rating (9.6 percent of income compared with 8.1 percent), their 57- to 64-year-old counterparts would see their financial burdens lesson by over 2 percentage points (13.9 percent of income compared with 16.0 percent). The impact on the other age groups would be substantially smaller. Median financial burdens for 21- to 27-year-old single-policy purchasers outside the subsidy eligibility range would be about half that for those age 57 or older; the differential would shrink under 3:1 rating, but the burdens would remain significantly higher for the older adults. Similar patterns are seen for family policies where the members have different age compositions.

Status of Current Nongroup Enrollees Under the ACA. Current (pre-ACA) young nongroup enrollees constitute a central concern related to the implications of new insurance market rules. This population is most at risk for experiencing disruptions to their current coverage. While tables presented above include all those purchasing coverage in the nongroup markets post reform (both those newly purchasing and those continuing on from prior nongroup coverage), we now change our focus to those with current nongroup coverage.

Table 5, section A shows the number (in thousands) of covered lives in today's nongroup market by age and status under the ACA.[11] As we saw previously, the one group for whom 3:1 age-rating bands potentially have the largest negative implications is young adults age 21 to 27. Of the 2.9 million adults in this age group with pre-ACA nongroup coverage, 67 percent would be eligible for either Medicaid or CHIP under the ACA or for exchange-based subsidies for the purchase of private nongroup insurance, thus being protected from the potential negative effects of age rating on their premiums. Of the remaining 33 percent, two-thirds are up to age 26 and in families with an offer of coverage from an employer (data not shown), and thus could obtain coverage that way instead of through the nongroup market via the ACA's provisions regarding expansion of dependent coverage in private plans. More than three-quarters of the 1 million younger adults (age 18 to 20) with nongroup coverage would also be eligible for financial protection under the law. Older adults with current nongroup insurance coverage, those most assisted by the ACA's 3:1 age-rating bands, are significantly less likely to be eligible for financial assistance under the law than their younger counterparts.

Status of Currently Uninsured Under the ACA. Table 5, section B shows the post-reform eligibility status of those currently uninsured, by age. Young adults without insurance far outnumber those young adults with

Table 5:

A. Post-Reform Eligibility Status of Those with Current Nongroup Coverage, by Age Group
(numbers in thousands)

	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		
Age group	Number Currently Covered	Share of Those Currently Covered	Number Currently Covered	Share of Those Currently Covered	Total with Current Nongroup in Age Group
18–20	785	78.0%	221	22.0%	1,006
21–27	1,927	66.9%	951	33.1%	2,878
28–44	1,434	41.0%	2,067	59.0%	3,501
45–56	1,342	41.4%	1,903	58.6%	3,244
57–64	1,105	50.3%	1,094	49.7%	2,199
Total	6,593	51.4%	6,235	48.6%	12,828

B. Post-Reform Eligibility Status of Those Currently Uninsured, by Age Group
(numbers in thousands)

	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		
Age group	Number Currently Uninsured	Share of Those Currently Covered	Number Currently Uninsured	Share of Those Currently Covered	Total Currently Uninsured in Age Group
18–20	1,918	82.7%	400	17.3%	2,318
21–27	6,954	70.5%	2,913	29.5%	9,867
28–44	10,700	62.9%	6,307	37.1%	17,007
45–56	7,065	66.2%	3,615	33.8%	10,680
57–64	3,167	74.3%	1,098	25.7%	4,265
Total	29,804	67.5%	14,333	32.5%	44,137

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Analysis based on the ACA in 2017.

nongroup coverage today. For example, almost 10 million 21- to 27-year-olds today are uninsured, compared with just under 3 million with nongroup coverage. Over 70 percent of uninsured young adults will be eligible for financial assistance—either through Medicaid or the exchanges—once the ACA is implemented. Over 80 percent of uninsured young adults age 18 to 20 will also be eligible for Medicaid or tax credits in the nongroup exchanges. Consequently, the vast majority of these young adults, a central target population for enrollment in the nongroup market beginning in 2014, will also be shielded from significant financial effects of the change to narrower age-rating bands.

Aggregate Costs and Rates of Insurance Coverage. Consistent with our previous analyses on the distributional effects of age-rating options,[12] the current analysis shows virtually no difference in overall insurance coverage of the nonelderly across age-rating scenarios (appendix table 1). In addition, there is extremely little difference in the distribution of insurance coverage within age categories. Also consistent with our earlier work, aggregate government, employer and household costs under the ACA are not significantly affected by the choice of age-rating bands, with aggregate costs differing by less than 1 percent between 3:1 and 5:1 rating (appendix table 2). While larger percentages of young adults are eligible for exchange-based subsidies due to being lower income, lowering their premiums does not decrease total federal subsidies significantly since the average premiums for the older adults increase so substantially under 5:1 rating.

Conclusions

The modified community rating rules that will be implemented under the ACA in January 2014 will change how individually purchased insurance premiums will be determined in the vast majority of states. The law will significantly reduce the current market's variation in premiums between older and younger adults purchasing the same coverage. However, the claims by some in the insurance industry that this change will have dramatic implications for the out-of-pocket costs of young adults are unfounded. Those most affected by the changed rating rules will be those age 21 to 27, for whom average premiums will tend to be higher under 3:1 rating than under looser rating rules, and those age 57 and above, for whom average premiums will tend to be lower under 3:1 rating. However, the 3:1 age gradient developed by CMS is a reasonable proxy for the health expenses of those expected to enroll in the new nongroup marketplace, particularly for those up to age 27 and for those age 42 and older.

Appendix Table 1: Distribution of Health Insurance Coverage Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals 2017

Age Group	Age Rating Restriction	Private Health Insurance	Public Coverage	Uninsured	Total
Children, < 18	3:1	53.4%	41.4%	5.2%	100.0%
	5:1	53.4%	41.4%	5.2%	100.0%
18–20	3:1	34.5%	48.3%	17.2%	100.0%
	5:1	34.5%	48.3%	17.2%	100.0%
21–27	3:1	55.5%	28.5%	16.1%	100.0%
	5:1	55.5%	28.8%	15.7%	100.0%
28–44	3:1	71.5%	16.0%	12.4%	100.0%
	5:1	71.6%	16.1%	12.3%	100.0%
45–56	3:1	73.5%	17.7%	8.8%	100.0%
	5:1	73.5%	17.7%	8.8%	100.0%
57–64	3:1	65.4%	26.4%	8.2%	100.0%
	5:1	65.4%	26.4%	8.2%	100.0%
All nonelderly	3:1	63.3%	27.2%	9.4%	100.0%
	5:1	63.4%	27.3%	9.4%	100.0%

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017.

Appendix Table 2: Aggregate Government, Employer, and Household Costs for the Nonelderly Under Comprehensive Health Care Reform by Premium Age Rating Option 2017 (in billions)

	Reform	
	3:1	5:1
Government Spending		
Medicaid/CHIP and household subsidies	597	597
Employer subsidies	6	5
Less assessments and penalties	8	8
Net government spending	595	594
Uncompensated Care	48	47
Employer Spending, incl. assessments	844	838
Household Spending, incl. penalties	482	480
Total Public and Private Spending	1,969	1,959

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Household spending includings health insurance premium payments by workers and others as well as direct out-of-pocket spending on medical care.

In addition, large majorities of the young adults purchasing nongroup insurance today, those uninsured today, and those expected to purchase nongroup coverage under the fully implemented ACA, would be shielded from the negative effects of tighter age-rating rules. This financial protection will come from the availability of federal subsidies for the purchases of private nongroup insurance and, for some current nongroup purchasers and the currently uninsured, the expanded Medicaid program.

Appendix: Methodology

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.[13] The core of the national model is two years of the Current Population Survey's Annual Social and Economic Supplement, matched to several other national datasets, including the Medical Expenditure Panel Survey-Household Component.[14] Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We choose 2017 because we expect that behavioral changes by individuals and employers to the reforms being implemented in 2014 will have reached equilibrium at most three years after implementation.

This approach differs from that of the Congressional Budget Office (CBO) or the Centers for Medicare and Medicaid Services (CMS) actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief and are not repeated here.[15]

For purposes of this analysis, we assume that the nongroup and small group markets are not pooled together in computing premiums. However, states choosing to do so could decrease the magnitude of any nongroup premium increases associated with the ACA.[16] Small firms are defined as those of 100 (full-time-equivalent) or fewer workers as all states must use this definition beginning in 2016. We simulate the affordability exemption to the individual mandate that observers expect to be in the forthcoming regulations; this differs from the interpretation of the Joint Committee on Taxation and CBO that we used in earlier modeling. We assume that dependents will not incur mandate penalties if they do not obtain coverage and the lowest available family premium is above 8 percent of family income. A family would still be barred from subsidized exchange coverage if the lowest single premium offered to one member was less than 9.5 percent of family income. The Basic Health Plan option was not modeled.

The Supreme Court's ruling on the ACA means that states may decide whether or not to expand Medicaid coverage to nonelderly adults. Our analysis assumes that all states take advantage of the opportunity to increase eligibility to those with incomes below 133 percent of FPL. Beginning in 2014, states do not have to maintain Medicaid eligibility for adults above 133 percent of FPL. We assume that states would discontinue eligibility for adults eligible under Section 1115 waivers or Section 1931 who are above that income threshold. Other categories of adults could be affected, notably the medically needy and pregnant women, but we do not model any change in their eligibility due to the difficulty in identifying them in our underlying survey data.

We assume that college student plans are required to be Essential Health Benefit compliant plans starting in 2014. The structure of the CPS is intended to include students temporarily residing away at college in their parents' permanent residence if they are tax dependents of their parents. Consequently, full-time students reporting on the CPS that they reside independently are treated as independent tax units. However, we recognize that the survey may not correctly identify all full-time students living at school as to whether they are tax dependents of their parent or not, particularly those living outside university housing.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,[17] which is referenced in the final rules as well.[18] Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With 4:1 and 5:1 rating, we followed the same approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the notice of proposed rulemaking.[19] As a result, premiums will vary not only with the age, but also by the number of individuals in the family.[20]

A number of factors that could impact premium differences by age are not taken into account here. We do not model the option for catastrophic coverage for adults under age 30 as provided under the ACA. This coverage option makes lower-cost coverage with higher cost-sharing requirements than the bronze level available to young adults, creating a lower premium option than those modeled here. As a consequence, average premiums for the young adults presented will overstate the actual averages under full implementation of the law. In addition, we do not model specific tobacco use–related premium adjustments (permitted in the small group and nongroup markets under the ACA) or premium adjustments due to wellness programs (permitted in the group market under the ACA). Tobacco adjustments are more likely to increase premiums of younger adults than older adults as they are somewhat more likely to use tobacco products.[21] Wellness adjustments are more likely to increase premiums of older adults, as the health problems they most frequently target (e.g., high blood pressure, high cholesterol, abnormal blood sugar) are more likely to occur among the older population. Depending upon how widespread these premium rating approaches are used, they could significantly affect decisions of adults of different ages and their decisions to enroll in insurance coverage in the small group and nongroup markets, and thus could also affect premiums in those markets.

We simulate age rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant and assuming a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution.

Endnotes

[1] For example, Karen Ignani, says, "Unless the restrictions on age rating are loosened, younger people will face significant cost increases at the same time the broader coverage expansion begins to take effect in 2014" ("Now is the time to focus on affordability," http://blogs.reuters.com/great-debate/2012/07/10/now-is-the-time-to-focus-on-healthcare-affordability/).

[2] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[3] http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf.

[4] http://www.ofr.gov/OFRUpload/OFRData/2013-04335_PI.pdf.

[5] A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students age up to age 23.

[6] For the remainder of this paper, "family" is used to refer to the health insurance unit.

[7] For example, in a small number of cases, older adults purchase plans from a higher tier under 3:1 rating than they would under 5:1 rating because the more comprehensive coverage is more affordable under the narrower rating bands.

[8] Single policies each cover one individual (i.e., number of policies is equal to the number of people covered by those policies). Each family policy covers more than one person.

[9] 92 percent is calculated from table 4 as follows: In 2017, we estimate that the total number of single policies for adults age 21 to 27 held through nongroup exchange plans will be 1,429,000. We also estimate that 1,317,000 of those policies will be held by individuals with income at or below 300 percent of FPL. 1,317,000/1,429,000 = 92 percent.

[10] Another 4 percent of this age group has income between 300 and 400 percent of FPL. They are eligible for subsidies by virtue of their income, but as we saw earlier, under 5:1 rating some will not actually receive a subsidy because the premium cost they would face is less than the 9.5 percent of income premium cap they receive from the federal government.

[11] Here, we include full-time adult students reporting nongroup coverage under the current system. Although much of this coverage is student insurance through colleges and universities, we are unable to identify specifically the source of any particular nongroup plan.

[12] Blumberg LJ, Buettgens M and Garrett B. "Update: Age Rating under Comprehensive Health Care Reform." Insight on the Issues brief. Washington: AARP, 2010. Available at http://assets.aarp.org/rgcenter/ppi/health-care/i000-age-rating.pdf; and Blumberg LJ, Buettgens M and Garrett B. "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens." Timely Analysis of Immediate Health Policy Issues. Washington: The Urban Institute, 2009. Available at http://www.urban.org/publications/411970.html.

[13] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[14] HIPSM uses data from several national datasets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

[15] Buettgens M, Garrett B, and Holahan J. "America under the Affordable Care Act." Washington: The Urban Institute, 2010. http://www.urban.org/publications/412267.html.

[16] See Blavin F, Blumberg LJ, Buettgens M, Holahan J and McMorrow S. "How Choices in Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage." Health Affairs 31 (2012):2290–2298. Relatedly, The November Notice of Proposed Rulemaking on market rules (http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf) specifically allows small groups and small group issuers to "deconstruct" group premiums, assigning the underlying age-adjusted (and tobacco-adjusted) cost of coverage to each member of the group. Depending upon the frequency with which small employers and carriers use this option, and depending upon how those employers structure their premium contributions and how that affects workers of different ages, some workers could change their insurance enrollment decisions, which could in turn affect small group and nongroup risk pools and premiums. We do not take this possibility into account in the estimates presented here.

[17] http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf.

[18] http://www.ofr.gov/OFRUpload/OFRData/2013-04335_PI.pdf.

[19] A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students up to age 23.

[20] "Family" is used to refer to the health insurance unit.

[21] Trends in Tobacco Use. Washington: American Lung Association, 2011. Available at http://www.lung.org/finding-cures/our-research/trend-reports/Tobacco-Trend-Report.pdf.

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BostonHerald.com

Analysis: Mass. individual health premiums highest in nation

Tuesday, August 9, 2011

By:

Michael Norton

Massachusetts and Vermont led the nation in 2010 with average, individual market health insurance premiums topping $400 per person per month, about double the national average, according to an analysis released Tuesday.

The Kaiser Family Foundation used information culled from insurer filings to the National Association of Insurance Commissioners and found a substantial spread among premiums between the states.